Grayson County Indigent Program

809 Gallagher Drive, Suite D
Sherman, Texas 75090
Phone: 903-771-2851
Fax: 903-771-2850

Open Interviews are conducted Monday through Thursday from 8am – 11am and 1pm – 4pm.

- The Grayson County Indigent program is a county funded program that helps residents of Grayson County pay for medical care on a short-term basis. Whether you are eligible depends on your income, where you live, help you receive, and other items.

- Open interviews are conducted Monday through Thursday from 8am-11am and 1pm-4pm except on the following holidays; New Year's Day, Good Friday, Memorial Day, July 4th, Labor Day, Veteran's Day, Thanksgiving, the Friday after Thanksgiving, Christmas Eve, Christmas Day, the 3rd Thursday of each month from 8am-1pm for staff meeting, and any other day specified by The Grayson County Indigent program.

- Open interviews are first come, first serve; based upon when the completed paperwork is turned in to the receptionist at the front desk. You may also have to provide additional information during the open interview process in order to determine your eligibility.

- The attached application, along with all required documentation (checklist is provided on page 2) must be provided in order for eligibility to be determined.

- Should you have any question, please contact our office Monday – Friday, 8am-12pm and 1pm-5pm.

- Guidelines, policies, the application, and/or the open interview process are subject to change at any time without notification.

| Revision date: 10/26/2021

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Indigent Program Required Documentation Checklist

Name: _____ Date of Birth: _____

Martial Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Medical Needs: _____

_____

- ✓ Complete application pages 2 to 10 (NOTE: some pages must be notarized)
- ✓ Original Texas Driver's License or Texas ID Card – MUST be valid and MUST have a Grayson County address on it
- ✓ Supporting documentation: You MUST provide all of the following documentation that applies to you and/or your spouse, and the documentation MUST be current.

******Yes No – please check one box for each******

◯ ◯ Paycheck stubs – past 30 days ◯ Applicant ◯ Spouse
◯ ◯ Social Security award letter ◯ Applicant ◯ Spouse
Note: If you are receiving Social Security Disability, we need paperwork stating your Medicare coverage effective date
◯ ◯ Federal Income Tax return (current year, including if you are claimed as a dependent on another person's tax return)
◯ ◯ Unemployment Compensation award letter ◯ Applicant ◯ Spouse
◯ ◯ Child Support / Texas Attorney General Statement (paying or receiving)
◯ ◯ Self-Employment / Contract work ◯ Applicant ◯ Spouse
◯ ◯ Pensions / 401 K / Retirement statement ◯ Applicant ◯ Spouse
◯ ◯ Veterans Benefits and/or payments ◯ Applicant ◯ Spouse
◯ ◯ Trust Fund / Stocks / Bonds ◯ Applicant ◯ Spouse
◯ ◯ Workers Compensation/Benefits letter ◯ Applicant ◯ Spouse
◯ ◯ Checking account statements (applicant/spouse: Individual/Joint Past 30 days, all pages
◯ ◯ Savings account statements (applicant/spouse: Individual/Joint Past 30 days, all pages
◯ ◯ Food stamp award letter

Note: You may be asked during your interview to provide additional information and/or documentation in order to determine your eligibility.

TEXAS
Health and Human Services

Form 3064
January 2020-E

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

For Office Use Only				
Status ○ Application ○ Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable

Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.

Have you ever used another name? If so, list other names you have used.
○ Yes ○ No

Mailing Address (Street or P.O. Box)	Apt. No.	City	State	ZIP Code

Home Address, if different from above. If it is rural, give directions.

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.

Name (Last, First, Middle)	**Social Security No.** (if available)	**Sex** (Male/ Female)	**Date of Birth**	**Relation to You**	**Are you a sponsored alien?**
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No

Note: The word "household" in Questions 2 through 16 refers to you, your spouse and anyone else who lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."

2. What is your household's county and state of residence (where you make your permanent home)?

County: _____ State: _____ Do you plan to remain in this county and state? ○ Yes ○ No

3. Living Arrangements – Check all boxes that apply to your household.

☐ Own or paying for home ☐ Live in a house provided by someone else ☐ No permanent residence
☐ Live with someone else ☐ Rent house or apartment ☐ Jail

4. List your average monthly household expenses.	
Rent/Mortgage	$
Utilities (gas, water, electric)	$
Phone	$
Transportation (such as gas, car payments, bus)	$
Tax and Insurance on Home Per Year	$
Other:	$
Other:	$
Other:	$

Does anyone pay these household expenses for you? ◯ Yes ◯ No If Yes, who pays? _____

5. Are you or is anyone in your household receiving any of the following? ◯ Yes ◯ No

☐ Temporary Assistance for Needy Families (TANF) ☐ Food Stamps ☐ Medicaid Benefits

If Yes, who? _____

6. Are you or is anyone in your household pregnant? ◯ Yes ◯ No If Yes, who? _____

7. Are you or is anyone in your household disabled? ◯ Yes ◯ No If Yes, who? _____

8. Have you or has anyone in your household applied for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)?

◯ Yes ◯ No If Yes, who applied and when? _____

9. Do you or does anyone in your household have unpaid health care bills from the last three months? ◯ Yes ◯ No

If Yes, which months? _____

10. Do you or does anyone in your household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, etc.)?

◯ Yes ◯ No If Yes, who? _____

11. How much money do you have in your wallet, in your home, in bank accounts or other locations? _____

12. How many cars, trucks or other vehicles do you and anyone in your household have? List the year, make and model below. _____

	Year	Make and Model	+
1			−

13. Do you or does anyone in your household own or pay for a home, lot, land or other things? ◯ Yes ◯ No

14. Did you or did anyone in your household sell, trade, or give away any cash or property during the last three months? ◯ Yes ◯ No

15. Have you or has anyone in your household worked in the last three months? ◯ Yes ◯ No If Yes, who? _____

16. List all of your household's income below. Include the following: government checks; money from training or work; money you collect from charging room and board; cash gifts, loans or contributions from parents, relatives, friends and others; sponsor's income; school grants or loans; child support; and unemployment.

Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received?

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility. I agree to report any of the following changes within 14 days:

- Income
- Resources
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party.

I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

Before you sign, be sure each answer is complete and correct. If the applicant is married and the spouse is a household member, the spouse may also sign and date this form, even if the spouse is a disqualified household member.

Signature — Applicant _____ Date _____ Signature — Spouse _____ Date _____

Signature — Person Helping Complete Form 3604 _____ Signature — Applicant's Representative _____ Signature — Witness (if applicant signed with "X") _____

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code): _____ Area Code and Phone No.: _____

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Grayson County Indigent Program Authorization for Release of Information

Applicants Name: _____

I hereby give permission to the Grayson County Indigent program to contact any source to verify the statements I have made in my application. I understand that a background check company and the Texas Workforce Commission may be contacted. I will cooperate fully with Grayson County Indigent program personnel to obtain any information necessary to verify statements about my eligibility. I understand that random home visits may be conducted.

I give permission to the Grayson County Indigent program to speak to the person listed below at any time regarding my eligibility or benefits under the Grayson County Indigent program.

_____	_____	_____
Name	Relationship to applicant	Phone number

I understand that my failure to meet the obligations set forth or the unlawful use of medical voucher, pharmacy card, etc., can result in the recovery of any loss by repayment, or by the filing of criminal or civil charges against me.

I give permission for my legal counsel or the Social Security Administration to release information regarding my application or appeal for Social Security benefits.

I also give permission for any providers rendering treatment to me to release my medical records to the Grayson County Indigent program for the purpose of determining proper referrals and/or determining whether or not the services rendered meet the criteria for payment by the Grayson County Indigent program.

This authorization is effective for the duration that the applicant remains in the program.

_____	_____
Applicant's signature	Date

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Acknowledgment for receipt of Grayson County Indigent Program Policies
documents included in the application

Grayson County Indigent Program Notice of Privacy Practice Policy

By signing below, I acknowledge I have received and read a copy of the Grayson County Indigent Program's Notice of Privacy Policy, and I understand its purpose.
I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I have read and understand that document. I consent to the use and disclosure, by Grayson County Indigent Program and its agents of my medical and health information and/or protected health information as is stated in the Notice of Privacy Practice. I understand that Grayson County reserves the right to change its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used and/or disclosed for treatment, payment, or health operations, but that Grayson County is not required to agree to the requested restrictions.
This authorization is effective for the duration that the applicant remains in the program.

_____ _____
Applicant's signature Date

Grayson County Indigent Program Fraud Policy

By signing below, I acknowledge I have received and read a copy of the Grayson County Indigent Program's Fraud Policy. I understand that if the Grayson County Indigent Health program staff determines that allegations against me of Fraud have merit, the staff has the discretion to discipline me in a manner consistent with violation of the Grayson County Indigent Program Fraud Policy, including by not limited to:

1. Termination from the program
2. The repayment of benefits
3. Criminal prosecution under the Texas Penal Code

This authorization is effective for the duration that the applicant remains in the program.

_____ _____
Applicant's signature Date

Grayson County Indigent Health Program Statement of Guidelines and Policies

By signing below, I acknowledge I have received and read a copy of the Grayson County Indigent Program's Statement of Guidelines and Policies. I have read and understand the guidelines and policies and understand the scope of healthcare services provided and the guidelines to remain in the program.
This authorization is effective for the duration that the applicant remains in the program.

_____ _____
Applicant's signature Date

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Grayson County Indigent Program Zero Income / Affidavit of Income and Support

If you (the applicant) have zero income, this form must be completed by the person that is providing support to and/or for you, no matter the type of support being provided. The person that is providing such support will need to complete this form in its entirety and have it notarized prior to the open interview process.

◯ Check this box if not applicable to you, sign and date below.

Please be informed that I, _____ (person providing the support), provided the

following support for _____ (applicant's name).

1. Are you related to the applicant? ◯ Yes ◯ No If yes, how? _____
2. Does the applicant live with you? ◯ Yes ◯ No If yes, how long? _____
3. Does the applicant pay rent? ◯ Yes ◯ No If yes, how much? _____
4. What type of support have you given to the applicant within the past 30 days?

   List: _____
5. Have you ◯ loaned or ◯ given (check one) any money to the applicant? ◯ Yes ◯ No
   If yes, amount given $_____
6. Is the applicant working? ◯ Yes ◯ No If yes, where? _____

I swear (affirm) that the contents of this affidavit signed by me are true and correct.

_____

Signature of person providing support/self Date Relationship to applicant/self

Subscribed and sworn to (affirmed) before me this _____ (day) of _____ (month), _____ (year), at

_____ (place of notary). Notary Public in and for the State of Texas.

My commission expires on _____ (MM/DD/YY).

_____

Notary Signature Seal

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Grayson County Indigent Program Employment Verification Form

◯ Check this box if not applicable to you, sign and date below.

Employer Name:		
Employee Name (as shown on your records)		
Employee Address – Street, City, State, Zip (as shown on your records)		
Rate of pay ◯ per hour ◯ per day ◯ per week ◯ per month	Average hours per pay period	How often is employee paid

Date hired	◯ permanent ◯ temporary ◯ full time ◯ part time
Is health insurance available? ◯ yes ◯ no If yes, employee is: ◯ enrolled ◯ declined ◯ not eligible	
Is this person on leave without pay? ◯ Yes ◯ No If yes, sate date of leave: _____ End date of leave: _____	

Comments:

_____ _____ _____
Signature of Person Verifying Information | Title of Person Verifying Information | Date

_____ _____
Employee/Applicant Signature (required) | Date

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Grayson County Indigent Program Self-Employment / Contract Work Form

◯ Check this box if not applicable to you, sign and date below.

Name of person who has self-employment income:

List your income:

Date	Description (example: mowed lawn)	Amount

The above information is true, correct, and complete to the best of my knowledge. I understand that giving false information to the Grayson County Indigent Program could result in my being disqualified for fraud.

_____ _____

Signature Date

Grayson County Indigent Program

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Grayson County Indigent Program Fraud Policy

Definition

- Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits

Procedure

When the Grayson County Indigent Health Program (GCIP) staff has reason to believe that fraud may have occurred, the following procedures shall be followed:

1. The GCIP staff shall investigate all cases of suspected fraud and shall collect and document evidence.
2. The GCIP staff shall contact the applicant/client who is suspected of fraud by sending a certified letter informing the applicant/client of the withdrawal of eligibility and explain the allegations. If the applicant/client disputes the allegations, the applicant/client will be allowed to submit applicable supporting documents/verification for further consideration.
3. If the dispute remains unresolved, the GCIP staff shall schedule an administrative hearing to allow the applicant/client to defend themselves by confronting any adverse witness and by presenting their own argument and evidence. The GCIP staff must disclose any evidence used to prove its case to the client so they have an opportunity to dispute it. The administrative hearing will be conducted by the Director of the Grayson County Health Department, the GCIP Program Manager, and the GCIP Eligibility Specialist. The administrative hearing shall be held at the office of the Grayson County Health Department or the Grayson County Indigent Healthcare during normal business hours. If the client does not appear at the administrative hearing, the GCIP eligibility specialist may proceed with the presentation of the GCIP's case. The Director of the Grayson County Health Department shall make a decision within ninety (90) days of the hearing.
4. The final decision for the appeal will be made by the Grayson County Health Department Director.

Consequence of Fraud

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person:

- Shall reimburse Grayson County for the cost of benefits they received, if they were ineligible to received benefits. Minimum monthly payments of $20.00 is required.
- Shall be administratively ineligible for GCIP benefits in accordance with GCIP policies and procedures; until debt is paid in full, and,
- May be subject to prosecution under the Texas Penal Code if no cooperation is provided.

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Grayson County Indigent Program Statement of Guidelines and Policies

- The Grayson County Indigent Program does not cover every medical need. Services not covered include, but are not limited to: cancer and/or the treatment of cancer, restricted medications, ambulance services, durable medical equipment, dental, vision, prenatal care, physical or occupational therapy, mental health services, and the treatment of/or hospital charges for drug and/or alcohol abuse or overdose.
- The Grayson County Health Clinic is the Primary Care Provider for all Grayson County Indigent Program clients.
- Clients must schedule an appointment with the Grayson County Health Clinic within one (1) week of being eligible.
- Clients are required to seek ALL non-emergency medical care from the Grayson County Health Clinic.
- Clients must notify the Grayson County Indigent Program office within fourteen (14) days of any changes, such as, but not limited to: income, job, address, telephone number, property (including vehicles), household members (such as getting married, or child or spouse moving in or out), and application/receipt of SSI, SSDI, TANF, or Medicaid.
- If a provider at the Grayson County Health Clinic determines that your condition requires treatment from a specialist, he/she will issue a referral for you to see a specific specialist. The Grayson County Indigent Program will not issue payment for any services rendered without a referral from the Grayson County Health Clinic. It is the client's responsibility to ensure that a valid referral is in place before seeing any specialist.
- Hospital emergency rooms are not to be used except in matters of true emergency. If you seek routine medical attention, such as, but not limited to, a sinus infection or back pain, you will be held responsible for the hospital bill and all related charges.
- The Grayson County Indigent Program will pay for up to three (3) prescriptions (restrictions apply) per calendar month, up to a thirty (30) day supply, and cannot exceed $500.00. Prescriptions can be filled at any pharmacy within Grayson County. Medication, such as, but not limited to: muscle relaxers, pain medications, mental health, and over the counter will not be paid for.
- The Grayson County Indigent Program and The Grayson County Health Clinic will work together to transition all available medications to the Medication Assistance Program. By doing this, clients will be contacted at the telephone number provided by the Grayson County Health Clinic, and may be required to come by the Grayson County Indigent Program office to sign any applications for new or renewal medications that the provider has requested. Clients may be asked to provide proof of income each time and could be contacted at various times, in an effort to get all medications available transitioned. Clients will also be contacted once a medication is received in the office and asked to come by and pick up. Deadlines will be given in an effort to ensure applications are signed in a timely manner and that medications are picked up in a timely manner.
- The program will cover up to $30,000.00 in medical expenses (including prescriptions) each fiscal year (September 1 – August 31).
- Clients will be interviewed monthly, every three (3) months, or every six (6) months, depending on the circumstances in order to maintain eligibility.

- Clients can be held responsible for the balance of charges not paid by the Grayson County Indigent Program, including full payment for prescriptions exceeding three (3) per month.
- Clients are responsible for informing providers of their eligibility with the Grayson County Indigent Program.
- Clients must carry the Medical Voucher card issued to them at all times. Failure to carry this card could result in an appointment with a provider to be canceled, or you may be asked to pay up front for any services rendered. The Grayson County Indigent Program office will not fax a copy to any provider.
- The Grayson County Indigent Program is not responsible for any medical claims received after our timely filing deadline of 95 days from the date of service. If a provider or facility sends a bill to the client, it is the client's responsibility to contact that provider or facility and inform them of their benefits with the Grayson County Indigent Program.
- All clients are required to notify the Grayson County Indigent Program if they are going to be outside of Grayson County for any reason, for a period longer than one (1) week.
- Clients must give information about healthcare insurance and any other third party financial liability for healthcare services.
- Clients may be asked to apply for additional benefits, to include, but not limited to: Medicaid, Healthy Texas Women's Medicaid, Supplemental Security Income (SSI), disability, or to register with the Texas Workforce Commission.
- Claims for medical services provided outside of Texas will not be paid for.
- Claims for medical services provided outside of Grayson County will not be paid for unless prior arrangements have been made and services pre-approved by the program manager.
- The Grayson County Indigent Program will terminate benefits if an appointment is missed with a caseworker.
- All applicants and/or clients are prohibited from displaying inappropriate behavioral and/or the use of abusive language towards staff, and failure to do so will result in him/her not being seen. The Grayson County Indigent Program staff will be protected from dangerous situations; physical or combative confrontations are not allowed.
- All clients are expected to comply with the medical regime proposed by the Grayson County Health Clinic, and/or by any Specialist to which the client was referred. Any referral for additional testing, such as lab, radiology, or other specialist referrals, must be completed in a timely manner.
- All clients are expected to give all physicians as least 24 hours advance notice to cancel an appointment, or if the client is unable to keep an appointment.

Above are the guidelines and policies of the Grayson County Indigent Program. Failure to comply with these guidelines and policies will result in benefits being terminated and the following outlines when the client will be eligible to reapply for benefits. Please note, if benefits are terminated, the individual will have to reapply and start the process over again.

1st offense: 30 days
2nd offense: 90 days
3rd offense: 180 days
4th offense: permanent dismissal

If a client is released from any provider, regardless of the reason, benefits with the Grayson County Indigent Program will be terminated and the client will not be eligible to reapply for benefits.

The guidelines and policies for the Grayson County Indigent Program are subject to change at any time without notice.

Grayson County Health Department
Notice of Privacy Practices

This notice describes how protested health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians and health care providers who may be treating you: i.e. your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or laboratory) who, at our request, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment
We are permitted to use and disclose your protected health information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from Medicaid or the Texas Department of Health. That form will contain medical information, such as a description of the medical services provided to you, that Medicaid or TDH needs to approve payment to us. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information

Health Care Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of our office. These activities include, but are not limited to: quality assessment activities; employee review activities; training of medical students, other practitioners, or non-health care professionals; accreditation; certification; licensing; credentialing; and conducting or arranging for other business activities. For example, we may use and disclose your protected health information when training and reviewing our staff. We may also use or disclose your protected health information, as necessary, to contact you to remind you of upcoming appointments.

If you are a job applicant, existing employee, or a family member of an employee covered by the County's health insurance, we will share your protected health information with the Grayson County Human Resources Department and/or supervising department as part of routine business operations. Some examples of situations where your information would be shared are: post-offer/pre-employment health screening outcomes, wellness screening outcomes, random drug screening outcomes, and Department of Transportation physical outcomes.
We will share your protected health information with third party "business associates" that perform various activities (e.g. auditing, legal) for us. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. This requirement will not apply if the business associate is a "health care component" designated by our governing body.

Protected health information may be shared with a school, about an individual who is a student or a prospective student of the school, if: the protected health information that is disclosed is limited to proof of immunization; the school is required by State or other law to have such proof of immunization prior to admitting the individual; and the covered entity obtains and documents the agreement to the disclosure from either: A parent, guardian, or other person acting *in loco parentis* of the individual, if the individual is an un-emancipated minor; or the individual, if the individual is an adult or emancipated minor.

We may use or disclose your protected health information, as necessary to provide you with information about treatment alternatives or other health-related benefits and services we offer that may be of interest to you. You may contact our Privacy Official to request that these materials not be sent to you.

If applicable, the agency will not use or share your health information without your authorization for marketing communications about a product, such as a drug or medical device, or services that encourage you to buy or use a product or service, except if the communication is in the form of: A face-to-face communication made by the agency to you, or a promotional gift of little value provided by the agency.
If the marketing involves direct or indirect payment to the agency from a third party, the authorization must state that such payment is involved. The following activities are not considered marketing and don't require your authorization: Refill reminders or other communications about a drug or biologic that is currently being prescribed for you, as long as any payment received by the agency in exchange for the communication is reasonably related to the agency's cost of the communication. Certain treatment and health-care operation activities, except where the agency gets payment in exchange for making the communication.

Emergencies
We may use or disclose your protected health information in an emergency treatment situation.

Other Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke this authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

If applicable, the agency must get your written authorization if it shares your protected health information for fundraising purposes, except the agency may use or share the following health information with a business associate or to an institutionally related foundation: Demographic information relating to an individual, including name, address, other contact information, age, gender, and date of birth; and dates of health care provided to an individual; department of service information; treating physician; health outcome information; and health insurance information. For example, the agency might participate in fundraising activities, organized by its state mental hospitals' volunteer services councils that are designed to improve the quality of patient care. These volunteer services council fundraising events are strictly voluntary and might include art shows, walks, runs, or bike rides. You must first provide the agency with your written authorization for any instance in which you choose to share your protected health information for such fundraising purposes

Other Permitted Uses and Disclosures to Which You May Agree or Object
We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are not present or unable to agree or object to such a disclosure because of your incapacity or an emergency circumstance, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your protected health information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your protected health information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose your protected health information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose protected health information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your protected health information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Communicable Diseases
We may disclose protected health information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Food and Drug Administration
We may disclose protected health information, to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as needed.

Legal Proceedings:
We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in response to a subpoena, discovery request or other lawful process as permitted by law. We may disclose protected health information in the course of any legal proceedings which seek reimbursement from a sponsor who signed an I-864 affidavit of support on your behalf.

Law Enforcement:
We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. Such disclosures include (1) the reporting of certain physical injuries; (2) responding to legal processes; (3) providing limited information for identification and location purposes, (4) providing law enforcement officials with information pertaining to victims of a crime; (5) reporting deaths possibly resulting from criminal conduct; (6) reporting a crime that occurs on our premises; and (7) reporting criminal activity outside our premises that results in emergency medical services.

Serious Threat to Health and Safety
We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person or the public. We may also disclose information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation
We may disclose your protected health information as required by workers' compensation law.

Inmates
We may release your protected health information to a correctional institution or law enforcement official if you are an inmate or under the custody of law enforcement. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your protected health information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release protected health information to researchers for research purposes. We may release protected health information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your protected health information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your protected health information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Sponsored Immigrant (I-864 Affidavit of Support)
Your protected health information may be disclosed as part of a request for reimbursement from a person who sponsored your admissibility into the United States by signing an I-864 on your behalf. Additionally, your protected health information may be disclosed in public legal proceedings if we pursue legal proceedings against a sponsor who signed an I-864 affidavit of support on your behalf.

Required by Law
We may release your protected health information when the disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Title45, Code of Federal Regulations, Parts 160 and 164

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information
You may request an amendment of your protected health information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this clinic or the physicians in this clinic.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. It excludes disclosure we may have made to you, to family members or friends involved in your care, for notification purposes, and for other purposes, as permitted by law. Please submit any request for an accounting to the person at the end of this document. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 and during the six years prior to your request. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

U.S. Department of Health & Human Services Office for Civil Rights
Medical Privacy, Complaint Division
200 Independence Avenue, SW
HHH Building, Room 509H
Washington, D.C., 20201

Phone: 866-627-7748
TTY: 886-788-4989

F. Our Promise to You

We are required by law and regulation to protect the privacy of your protected health information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact: ----------

Ms. Amanda Ortez, R.S., M.B.A., Director
515 N. Walnut St.
Sherman, TX 75090
903-893-0131 ext. 1223
Fax 903-892-3776
Email ortezа@co.grayson.tx.us

This notice effective April 14, 2003.