Grayson County Indigent Program

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

Open Interview Information

- Open interviews are conducted Monday through Thursday, from 8:00 AM to 11:00 AM and 1:00 PM to 4:00 PM.

Program Overview

- The Grayson County Indigent program is a county-funded initiative designed to assist eligible Grayson County residents with short-term medical care expenses. Eligibility is determined based on several factors, including income, residency, assistance received, and other qualifying criteria.

Open Interview Process

- Interviews are conducted on a first-come, first-served basis, determined by when completed paperwork is submitted to the front desk receptionist.
- You may be asked to provide additional documentation or information during your interview to complete the eligibility determination process.
- The application and all required documentation must be submitted for your case to be reviewed. A checklist is provided on page 2 of the application for your convenience.

Holiday Closures & Special Dates

- Open interviews will not be conducted on the following days: New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Veterans Day, Thanksgiving Day and the Friday following Thanksgiving, Christmas Eve, Christmas Day, the third Thursday of each month from 8:00 AM to 1:00 PM, and any additional dates specified by the Grayson County Indigent Health Care Program.

Contact Information

- If you have any questions, please contact our office:
  Monday through Friday, 8:00 AM to 12:00 PM and 1:00 PM to 5:00 PM.

Important Notice

- Program guidelines, policies, application requirements, and the open interview process are subject to change at any time without prior notice.

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Required Documentation Checklist

Name: _____ Date of Birth: ____/_____/_____

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

Medical Needs: _____

_____

- ✓ **Complete Application** (Pages 2 through 10)
  NOTE: some pages must be notarized
- ✓ **Valid Texas Driver's License or Texas ID**
  MUST be current, display a Grayson County address, and you must reside in Grayson County
- ✓ **Supporting Documentation**
  You must provide all applicable documentation for yourself and/or your spouse. Documents must be current.

Please check Yes or No for each item below and indicate who the documentation applies to:

Yes	No	Documentation Required	Applicant	Spouse
☐	☐	Paycheck stubs – past 30 days	☐	☐
☐	☐	Social Security award or case status letter *If receiving SSDI, include Medicare coverage effective date*	☐	☐/Child
☐	☐	Federal Income Tax Return 1040 *Current year, or copy of return claiming you as a dependent*	☐	☐
☐	☐	Unemployment Compensation award letter	☐	☐
☐	☐	Child Support / Attorney General Statement *Paying or receiving*	☐	☐
☐	☐	Self-Employment / Contract Income	☐	☐
☐	☐	Any type of Pensions / 401(K) / Retirement	☐	☐
☐	☐	Veterans Benefits / Payments	☐	☐
☐	☐	Any type of Trust Funds / Stocks / Bonds	☐	☐
☐	☐	Workers' Compensation award letter	☐	☐
☐	☐	Checking Account Transactions (individual/joint) *Past 30 days – all pages, must include name and account number*	☐	☐
☐	☐	Savings Account Transactions *(individual/joint)* *Past 30 days – all pages, must include name and account number*	☐	☐
☐	☐	Online Banking Transactions *(e.g., Venmo, Chime, Cash App)* *Past 30 days – all pages, must include name and account number*	☐	☐
☐	☐	Food Stamp award letter	☐	☐

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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

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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?

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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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The County Indigent Health Care Program (CIHCP) helps people pay for needed health care. Whether you can get this help depends on your income, what you own, where you live, other help you receive or could receive and other items. Be sure to:

1. Complete your name and address;
2. Sign and date Page 3 of the application; and
3. Answer as many questions as you can on this application.

Turn in or mail back your application today even if you cannot answer all the questions.

Your Responsibilities

You may be asked to bring proof of what you write on your application or what you tell the person interviewing you. If you need help getting proof, the person interviewing you will help. Examples of some of the items you may be asked to prove and documents you can use for proof are listed below.

Where You Live and Plan to Continue Living – Mail that you received at your address; school records; voting records; property taxes, rent or mortgage receipts; Texas driver license; and other official identification.

What You Own and What it is Worth – Property tax appraisals; estimates from car dealers; ads selling similar items; statements from real estate agents; and bank statements.

Your Income – Paycheck stubs; paychecks; W-2 tax forms or income tax returns; sales records; statements from employers; award letters; legal documents; and statements from persons giving you money.

Other Health Care Coverage – Award or claim letters; insurance policies; court documents; and other legal papers.
Information regarding Social Security numbers should be given if this information is available. Information regarding sex (male/female) is voluntary. This information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services paid by the county for yourself and members of your household. By signing and submitting this application, you are agreeing to give the county the right to recover the cost of health care services provided by the county from any third party.

You may be asked to apply for Medicaid, Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits. If you are asked to apply for one of these programs, or have applied but are waiting for an answer, your CIHCP application may be pended until you are determined ineligible for the other program. If you are not eligible for these other programs and if you have answered all the questions on the application and have given all the proof asked for, your application can be processed. Then, the CIHCP must determine if you are eligible within 14 days.

After turning in your application, you must report within 14 days any changes in your address, income, resources, people living with you, or application for or receipt of Medicaid, TANF or SSI.

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Authorization for Release of Information

Applicant Name: _____

I hereby authorize the Grayson County Indigent Program to contact any person, organization, or agency necessary to verify the statements I have made in my application. I understand that this may include, but is not limited to, background check services and the Texas Workforce Commission.

I agree to cooperate fully with the program personnel in obtaining any required information to determine my eligibility. I also acknowledge that random home visits may be conducted as part of the eligibility verification process.

Emergency Contact and Authorized Representative

I give permission for the Grayson County Indigent Program to communicate with the individual listed below regarding my eligibility and benefits. This individual will also serve as my emergency contact.

_____	_____	_____
Name	Relationship to Applicant	Phone Number

Acknowledgements and Additional Authorizations

I understand that failure to meet program obligations or the unlawful use of any issued medical voucher, pharmacy card, or other program benefit may result in repayment obligations and/or the filing of criminal or civil charges against me.

I authorize the release of information by my legal counsel and/or the Social Security Administration regarding any application or appeal for Social Security benefits.

I further authorize any healthcare provider who renders treatment to me to release medical records to the Grayson County Indigent Program, solely for the purpose of determining proper referrals and whether services rendered qualify for program payment.

This authorization shall remain in effect for the entire duration of my enrollment in the Grayson County Indigent Program.

_____	_____ / _____ / _____
Applicant Signature	Date

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Acknowledgment for Receipt of Program Policies

(Documents included in the application)

Notice of Privacy Practices

By signing below, I acknowledge that I have received and reviewed the Grayson County Indigent Program's Notice of Privacy Policy. I understand its purpose and contents.
I have been informed of how my medical and health information may be used and disclosed. I consent to the use and disclosure of my protected health information by the Grayson County Indigent Program and its agents, as described in the notice. I understand that Grayson County reserves the right to amend its notice and policies regarding the use and disclosure of health information at any time. I also understand that I may request limitation on how my health information is used or shared for treatment, payment, or healthcare operations, but that the program is not required to agree to these requests.

This authorization remains effective for the duration of my participation in the program.

_____ _____ / _____ / _____
Applicant Signature Date

Fraud Policy

By signing below, I acknowledge that I have received and read a copy of the Grayson County Indigent Program's Fraud Policy.
I understand the seriousness of program violations and acknowledge the possible consequences of committing fraud, which includes but is not limited to:

1. Permanent dismissal from the program
2. Repayment of any benefits received
3. Criminal prosecution under the Texas Penal Code

This authorization remains effective for the duration of my participation in the program.

_____ _____ / _____ / _____
Applicant Signature Date

Statement of Guidelines and Policies

By signing below, I acknowledge that I have received and read the Grayson County Indigent Program's Statement of Guidelines and Policies. I understand the healthcare services available through the program and the expectations and requirements necessary to maintain eligibility.

This authorization remains effective for the duration of my participation in the program.

_____ _____ / _____ / _____
Applicant Signature Date

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Zero Income / Affidavit of Income and Support

If you (the applicant) have zero income, this form must be completed by the person providing financial and/or material support to you – regardless of the type of support. This form must be completed in full and notarized prior to the open interview process.

☐ Check this box if this form is not applicable to you.

_____ _____ / _____ / _____
Applicant Signature Date

To be complete by the by the person providing financial and/or material support:

Please be informed that I, _____ (Full name of person providing support),

provide support for _____ (Applicant's full name).

1. Are you related to the applicant? ☐ Yes ☐ No If yes, how? _____
2. Does the applicant live with you? ☐ Yes ☐ No If yes, for how long? _____
3. Does the applicant pay rent? ☐ Yes ☐ No If yes, how much? $_____
4. What type of support have you provided to the applicant in the past 30 days?
   (Examples: food, shelter, utilities, transportation, financial aid, etc.)

   _____

   _____
5. Have you loaned or given money to the applicant? ☐ Yes ☐ No
   If yes, check one: ☐ Loaned ☐ Given Amount: $ _____
6. Is the applicant working? ☐ Yes ☐ No If yes, where? _____

I swear (or affirm) that the information provided in this affidavit is true and correct to the best of my knowledge.

_____ _____/_____/_____ _____
Signature of person providing support Date Relationship to Applicant

To be completed by a Notary:

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/YYYY).

_____
Notary Signature Seal

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Employment Verification Form

☐ Check this box if this form is not applicable to you.

_____ _____ / _____ / _____
Applicant Signature Date

To be completed by Employer.

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, Start Date of Leave: _____/_____/_____ End Date of Leave: _____/_____/_____	

Comments:

I certify that the information provided above is true and current to the best of my knowledge.

_____ _____ / _____ / _____
Signature of Person Verifying Employment Date

_____ _____ / _____ / _____
Employee / Applicant Signature (required) Date

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Self- Employment / Contract Work Income Form

☐ Check this box if this form is not applicable to you.

_____ _____ / _____ / _____
Applicant Signature Date

To be completed by the individual with self-employment or contract income.

Self-Employment / Contract Work Income Log

Date	Description of Work (e.g., mowed lawn)	Amount Earned $

I certify that the information listed above is true, correct, and complete to the best of my knowledge. I understand that providing false information to the Grayson County Indigent Program may result in disqualification from the program and could be considered fraud.

_____ _____ / _____ / _____
Applicant Signature Date

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Fraud Policy

Definition of Fraud

- Fraud is defined as the deliberate misrepresentation of a material fact with the intent to obtain benefits under false pretenses.

Procedure

When the Grayson County Indigent Health Program staff has reason to suspect fraudulent activity, the following steps will be taken:

1. ***Investigation***
   Staff will conduct a thorough investigation into any suspected fraud and will collect and document relevant evidence.
2. ***Notification***
   A certified letter will be sent to the applicant/client suspected of fraud, informing them of the withdrawal of eligibility and outlining the allegations.
   - The client will have the opportunity to dispute the allegations and submit supporting documents or verifications for further review.
3. ***Administrative Hearing***
   If the dispute is not resolved through documentation, the Grayson County Indigent Program staff will schedule an administrative hearing.
   - The applicant/client may present evidence, respond to the allegations, and confront adverse witnesses.
   - All evidence being used by the Grayson County Indigent Program will be disclosed to the client.
   - The hearing will be conducted by:
     - The Director of the Grayson County Health Department
     - The Grayson County Indigent Program Manager
     - The Grayson County Indigent Program Eligibility Specialist.
   - The hearing will take place at the offices of the Grayson County Health Department or Indigent Health Program during regular business hours.
   - If the client does not appear, the Grayson County Indigent Program may proceed with presenting its case in their absence.
   - A final decision will be issued by the Director within 90 days of the hearing date.
4. ***Final Decision***
   The Director of the Grayson County Health Department will render the final decision on the case.

Consequence of Fraud

If, after due process, an individual is determined to have intentionally misrepresented information to receive benefits:

- They must reimburse Grayson County for the full cost of ineligible benefits received.
  - A Minimum monthly repayment of $20.00 will be required.
- They will be administratively ineligible for the Grayson County Indigent Program until the debt is paid in full.
- They may be subject to criminal prosecution under the Texas Penal Code if they fail to cooperate with the repayment process or provide additional fraudulent information.

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Program Statement of Guidelines and Policies

The Grayson County Indigent Program provides limited, short-term medical assistance to eligible residents of Grayson County. Participation in the program requires strict compliance with the following guidelines and policies. Failure to do so may result in benefit termination and future ineligibility.

General Medical Services

- The program does not cover all medical needs. Services not covered include (but are not limited to): cancer treatment, restricted medications, ambulance services, durable medical equipment (DME), dental, vision, prenatal care, physical/occupational therapy, mental health services, and treatment of or hospital charges related to drug/alcohol abuse or overdose.
- The Grayson County Health Clinic is the Primary Care Provider (PCP) for all Grayson County Indigent Program clients.
- Clients must schedule an appointment with the Grayson County Health Clinic within one (1) week of program eligibility.
- Clients are required to obtain all non-emergency care through the Grayson County Health Clinic.
- Clients must be regularly seen at the Grayson County Health Clinic.

Client Responsibility

- Report changes within 14 days, including (but not limited to): Income, employment, address, phone number, property ownership, household members (such as getting married, or child or spouse moving in or out), or application or receipt of SSI, SSDI, TANF, or Medicaid.
- Notify Grayson County Indigent Program if you will be outside of Grayson County for more than one (1) week.
- Carry your Medical Voucher card at all times. The program will not fax cards to providers.
- Inform all healthcare providers that you are a Grayson County Indigent Program client.

Referrals and Specialist Care

- Specialist visits require a referral from a Grayson County Health Clinic provider. The program will not pay for specialist visits without a valid referral.
- Follow-up referrals for lab work, radiology, or other services must be completed in a timely manner.

Emergency Room Usage

- Emergency rooms are for true emergencies only. Seeking routine care (e.g. sinus infection, back pain) in a ER will result in full financial responsibility for those charges.
- Free-standing ER's are not a covered service.

Prescriptions

- The program will pay for up to three (3) prescriptions per month, with a 30-day supply limit, not exceeding $500 total.
- Medications must be filled at Grayson County pharmacies (except CVS and Walgreens).
- The following types of medications will not be covered: muscle relaxers, pain medications, over-the-counter drugs, and mental health prescriptions.
- The Grayson County Indigent Program works to transition eligible medications to the Medication Assistance Program (MAP). Clients must:
    - Respond to MAP request.
    - Sign required documents within specified deadlines.
    - Provide updated proof of income.
    - Pick up medications within specified deadlines.

Coverage Limits

- The maximum annual coverage per client is $30,000.00, including prescriptions (September 1 – August 31).

Eligibility and Interviews

- Clients will be re-evaluated monthly, every 3 months, or every 6 months based on individual circumstances.
- Failure to attend an appointment with a caseworker will result in termination of benefits.
- Clients may be required to apply for additional benefits, including:
  - Medicaid
  - Healthy Texas Women's Medicaid
  - SSI/SSDI
  - Texas Workforce Commission registration

Medical Claims and Timely Filing

- Grayson County Indigent Program is not responsible for claims received more that 95 days after the date of service.
- Clients must contact providers directly about Grayson County Indigent Program benefits when receiving medical bills.
- Out-of-state medical services will not be covered.
- Out-of-county medical services will only be covered if pre-approved by the Grayson County Indigent Program Manager.

Conduct and Compliance

- Clients must:
  - Comply with treatment plans.
  - Give providers 24 hours' notice to cancel appointments.
  - Refrain from inappropriate behavior or abusive language toward staff (grounds for immediate removal).
  - Avoid physical confrontations (grounds for immediate removal).
- Failure to comply with any of the above may result in benefit suspension or termination.

Benefit Termination and Reapplication Policy

- Failure to comply with Grayson County Indigent Program guidelines will result in benefits being terminated. The following reapplication periods will apply:

Offense	***Reapplication Wait Time***
1st	30 days
2nd	90 days
3rd	180 days
4th	Permanent dismissal

- If a client is dismissed from a provider, benefits will be permanently terminated, and the client cannot reapply.
- All clients must comply with program requirements to remain eligible.

Note:

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

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Grayson County Health Department
Notice of Privacy Practices

This notice describes how protected 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 **orteza@co.grayson.tx.us**

This notice effective April 14, 2003.