Health Center of Southeast Texas

We offer services at the following 6 locations!

Cleveland
307 N. William Barnett
Cleveland, TX 77327
M-F 8am – 8pm
Open one Saturday a month
8am-12pm
Closed Sunday
Family Practice
Women's Health
Behavioral Health
Telepsychiatry
Pharmacy Class A

Shepherd
11 Woodland Park Drive
Shepherd, TX 77327
M-F 8am – 6pm
Closed Weekends
Family Practice
Women's Health
Behavioral Health
Telepsychiatry

Liberty
1400 N. Travis Street
Liberty, TX 77575
M-F 8am – 6pm
Closed Weekends
Family Practice
Women's Health
Behavioral Health
Telepsychiatry

Livingston Family Practice/Pediatric
204 West Park Drive
Livingston, TX 77351
M-W 8am – 8pm
Th-F 8am – 6pm
Closed Weekends
Family Practice
Women's Health
Behavioral Health
Telepsychiatry

Dayton
2206 N.Cleveland
Dayton, TX 77535
M-T 8am – 5pm
W 8am – 8pm
Th-F 8am – 5pm
Closed Weekends
Family Practice
Pediatric

Terrenos
871 CR 3549
Cleveland, TX 77327
M-T 8am - 8pm
W-F 8am – 6pm
Closed Weekends
Family Practice
Women's Health
Pediatric

Our Mission is to provide accessible, compassionate, culturally competent, and quality health care, affordable for all, regardless of the ability to pay.

Please review us on:

www.hcset.com

Instagram

Health Center of Southeast Texas

SLIDING FEE SCALE DISCOUNT PROGRAM

Registration Information

The information below is needed by HCSET's Eligibility Department to determine if you qualify for discount programs provided by the Health Center. This information is confidential and will be strictly used to identify resources available to you and your family. In order to do so we will need the following:

INFORMATION REQUESTED:

- ☐ **Completed Application:** Instruction on how to fill out this application is in the back of the form. This will be a household application if the household consist of more than one individual.
- ☐ **Proof of Identity:** You and those applying will need proof of identity. Valid documents may consist of any of the following: Valid driver's license, state identification card, student ID with picture, passport with picture, U.S. immigration documents with picture, birth certificate, voter's registration card.
- ☐ **Healthcare Coverage:** You will need to provide proof of any health coverage. Valid documents include: Insurance cards, (Medicaid, Medicare, CHIP, CHIP prenatal, private insurance). If you have limited benefits and want to apply for the Sliding Scale Discount Program, we will have to first verify your benefits and require proof of household income and proof of household composition.
- ☐ **Proof of Household Composition *(This is a requirement to qualify for the Sliding Fee Discount Program)*:** Household composition is self declared. However, if you are the conservator or legal guardian of someone you must provide legal documentation proving that. Valid documents include: Birth certification, school documents, divorce or child support decree, or any other legal document.
- ☐ ***Proof of Household Income (This is a requirement to qualify for the Sliding Fee Discount Program):*** You will need to provide proof of income for anyone working in the household. Valid documents include: Check stubs within the last 60 days, income verification form or letter, Current income tax return with attachments, self employed pension, child support, social security award letter, unemployment, workmen's compensation, retirement checks or statements, self employment form with receipts and/or other documents, etc.
- ☐ **Valid Phone Number:** You will have to provide a working phone number where you can be reached. Examples: Home/Work/Cell/Emergency Contact. This information is very important for us to help you receive the best care possible.

The Sliding Fee Discount Program is based off of household composition and household income; no other factors. The Health Center will not deny services to anyone due to inability to pay.

If you have any questions regarding any of the requirements, please ask the receptionist.

NOTICE: Please be aware it is the responsibility of the applicant to notify HCSET of any changes or updates to their income/ employment/household status as this could affect the eligibility. If you are qualified for financial assistance and it is later determined that the information or proof you provided on this application is false, you may lose your financial assistance, may be barred from reapplying for six months, and be required to repay HCSET for any services rendered.

March 2024

Sliding Fee Discount Program

This application should be used to apply for the Sliding Fee Discount Program. If found potentially eligible for any other program, another application may be needed.

Section I. Applicant Information

***If applying for a child, the parent or legal guardian must be listed as the applicant.**

Name of Individual	Sex	Date of Birth	Race or Ethnicity	
Home Address	City	County	State	ZIP Code
Primary Area Code and Phone No.	Secondary Area Code and Phone No.			
Email Address				

Communication Preferences

The following fields do not affect eligibility. (Check all that apply)

How may we contact you? ☐ Email ☐ Phone ☐ Mail

Preferred Spoken Language ☐ English ☐ Spanish ☐ Other: _____

Preferred Written Language ☐ English ☐ Spanish ☐ Other: _____

Section II. Household Members

List all Household Members. Household members include the applicant and anyone who lives with them and for whom they are legally responsible for. Children under age 18 may be included as household members. Unborn children of pregnant women must be included as household members. See application instructions for more information on household members.

Number of Household Members: _____

Name *(Last, First, Middle)*	**Date of Birth**	**Sex**	**Race or Ethnicity**	**Relationship to Applicant**	**Program Applying For?** (Give Details)	**Enrolled in a Health Insurance Plan?**
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Do you, or any other applicants, have an immediate medical or dental need? ☐ Yes ☐ No

Are you, or any other applicants, a veteran? ☐ Yes ☐ No

Important Information for Former Military Services Members – Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, visit the Texas Veterans Portal at **https://veterans.portal.texas.gov**.

Does any household member have any special circumstances that may affect their inclusion in the household member count? ☐ Yes ☐ No

If yes, please provide a detailed explanation:

Section III. Other Benefits

If you are applying for the grant program, you may be eligible for adjunctive eligibility*. Check all benefits you are currently receiving:

- ☐ Children's Health Insurance Program Perinatal (CHIP-P)
- ☐ Women, Infants, and Children (WIC) Program
- ☐ Healthy Texas Women (HTW)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Medicaid for Pregnant Women
- ☐ None of these

Section IV. Acknowledgement

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 any information necessary to prove statements about my eligibility. I agree to report all changes in income, family composition, residence, current address, employment and all types of health care coverage or benefits no later than 30 days after I become aware of the change. I understand that giving false information could result in disqualification and repayment.

Privacy Notification

With few exceptions, you have the right to request information that the state of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. (Government Code, Section 552.021, 552.023, 559.003 and 559.004.) _____ Initials

Acknowledgment

I understand that this application is a legal document and that by signing this form, I am stating that from my personal knowledge, all facts included are true and correct. I understand that giving false information could result in disqualification or reimbursement for the cost of services and that if I am approved to receive program services, I will be held accountable for complying with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities. _____ Initials

Statement of Release of Information

I authorize the release of income and medical information to and by the Texas Health and Human Services Commission and the provider, as necessary, to determine eligibility and to coordinate, render and bill for services. _____ Initials

Coverage Attestation

I attest that I, the primary applicant, have no other health insurance coverage than what is listed in Section III, Health Care Information, of this application. I authorize the program to bill the coverage sources listed for any services provided. _____ Initials

_____ _____

Applicant Signature **Date**

For Facility Office Use Only

Name of Applicant	Type of Determination ☐ New ☐ Re-Certification	Eligibility Start Date
Case Record Action ☐ Approved ☐ Presumptive ☐ BCCS ☐ Denied	HH #: _____ FPL: _____	Eligibility End Date

Section V. Acknowledgement

List gross household income and include documentation. Household income includes adult household member incomes. Refer to Appendix I of the Program Policy Manual "Definition of Income" for additional information about different types of income.

Name of Household Member Receiving Money	Name of Employer or Person Who Provides Money	Type of Income	Gross Amount Received	How Often Received *(weekly, bi-weekly, bi-monthly or monthly)*	Monthly Income Total
				Total Countable Monthly Income:	
				Allowable Deductions:	
				Net Countable Monthly Income:	

Notes:

Section VI. Eligibility Certification

All questions must be answered by eligibility staff on eligibility checklist.

Eligibility Effective Date: _____

Name of Client	Program Eligibility	Type of Eligibility Granted	Type of Determination *(New or Recertification)*	Copay Amount

By signing below, I attest that the above listed applicants have met program eligibility requirements. I have notified pregnant applicants they must apply for Medicaid for Pregnant Women or CHIP Perinatal. I have notified any applicants who appear eligible for other programs, including but not limited to, Medicaid or CHIP, must apply to those programs.

_____ _____ _____

Name of Facility **Staff Member Attestation Signature** **Date**