









<b>Amount Paid In Healthcare Expenses while Ineligible for Benefits</b>	<b>Denial Period</b>
\$ .01 to \$ 249.99	1 month
\$ 250.00 to \$ 999.99	3 months
\$1,000.00 to \$2,999.99	6 months
\$3,000.00 to \$4,999.99	9 months
\$5,000.00 or greater	12 months

- c) **Penalty Exception:** If amount owed to MCHD is equal to or less than \$500, the client may have benefits reinstated for 3 months from date of determination of fraud if an agreement is signed that full restitution will be made within the three month period.
- i. This exception only applies for client's first offense of fraudulent behavior.
  - ii. If full restitution is not made within that timeframe, then client will be administratively ineligible for timeframe established by penalty timeframe table starting from restitution deadline or until full restitution is made, whichever condition is met first.
2. Second Offense of fraud determined:
- a) Client must make full restitution to MCHD before being allowed reenrollment into HCAP; or
  - b) Client must serve penalty timeframe; and
  - c) Client must serve an additional 3 month penalty.
3. Third or more offense of fraud determined:
- a) Client must make full restitution to MCHD before being allowed reenrollment into HCAP; or
  - b) Client must serve full penalty timeframe; and
  - c) Client must serve an additional 6 month penalty added to penalty timeframe; and
  - d) Client must be granted permission to re-enroll in HCAP by MCHD Executive Officers.

**I hereby acknowledge, I have read and understand the above information stated in this document.**

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HCAP CLIENT SIGNATURE

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DATE





**MONTGOMERY  
COUNTY HOSPITAL  
DISTRICT**

Health Care Assistance Program  
1400 South Loop 336 West  
Conroe, Texas 77304  
Phone: 936-523-5100  
Fax: 936-539-3450

- \_\_\_\_ If I am involved in a motor vehicle accident (MVA) or an assault, this program will not pay for any medical expenses related to that accident or assault unless proper documentation is provided proving there is no other liability. I also understand that I must first *notify* the eligibility office within 14 days of this event and *provide* a police report and/or auto insurance information to the eligibility office as soon as possible.
- \_\_\_\_ On the application I signed it states, "I understand that by signing this application, I am giving MCHD the right to recover the cost of health care services provided by the MCHD from any third party. I agree to give MCHD any information it needs to identify and locate all sources of payment for health care services. I authorize any public or private agency to furnish MCHD or its agent information related to assets in my name and/or my criminal history, credit history, and employment history. I release MCHD, its employees and assigned agent and the agencies furnishing such information from liability resulting from the furnishing of this information to MCHD." I acknowledge that I have read, understand and agree to such statement.
- \_\_\_\_ It is my responsibility to reapply for HCAP benefits no earlier than 21 days before my card expires.
- \_\_\_\_ I understand the filing of an application form or receipt of HCAP health care services constitutes an assignment to Montgomery County Hospital District's Health Care Assistance Program of my right of recovery from (1) personal insurance; (2) other sources; or (3) another person for personal injury caused by the other person's negligence or wrong. Such assignment is limited to MCHD's costs expended on my behalf.
- \_\_\_\_ Since I have applied for health care assistance or will receive health care services, I agree to inform the Hospital District's Health Care Assistance Program, at the time of application or at any time during eligibility, of any unsettled tort claim that may affect medical needs and of any private accident or sickness insurance coverage that is or may become available. As an applicant, I agree to inform the District of any injury that is caused by the act or failure to act of some other person. As an applicant, I agree to inform the District immediately and in no event later than 14 days of the date in which I learn of any insurance coverage, tort claim, or potential cause of action.
  - A separate and distinct cause of action in favor of the District is hereby created, and the District may, without written consent, take direct civil action in any court of competent jurisdiction. A suit brought under need not be ancillary to or dependent on any other action.
  - The District's right of recovery is limited to the amount of the cost of services paid by the District.
  - As an applicant, if I knowingly and intentionally fail to disclose the information required by the District, I understand I will have committed a Class C misdemeanor.
- \_\_\_\_ As an applicant, I may be subject to denial of HCAP services following an appeals (administrative) hearing as set forth in the HCAP handbook.
- \_\_\_\_ I certify that the statements made by me on this form and on my application for health services are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that any false statements made herein or on my application for health services from Montgomery County Hospital District will void further consideration for eligibility in Montgomery County Hospital District's Health Care Assistance Program as it relates to my application for such health services.









# MONTGOMERY COUNTY HOSPITAL DISTRICT

- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- We may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals.
- We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Your authorization is required for:** (1) Any use or disclosure of Psychotherapy notes, except as needed to carry out treatment, payment, or health care operations; or use by the originator of the psychotherapy notes for treatment; and (2) Marketing activities, except our face to face communications with you; and (3) Sale of PHI.

Any other use or disclosure of PHI not described in this notice will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

**Patient Rights:** As a patient, you have a number of rights with respect to the protection of your PHI, including:

**The right to access, copy or inspect your PHI:** This means you may come to our offices and inspect and copy the PHI that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer under the contact information listed at the end of this Notice.

**The Right to Confidential Communications:** You have the right to receive confidential communications of your PHI.

**The right to amend your PHI:** You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct in our records. If you wish to request that we amend the medical information that we have about you, you should contact the privacy officer under the contact information listed at the end of this Notice.

**The right to request an accounting of our use and disclosure of your PHI:** You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. We are also **not required** to give you an accounting of our uses of PHI for which you have already given us written authorization. Your accounting will be provided without charge; however, MCHD may charge a reasonable fee for additional accounting requests made by the same individual during a 12 month period. If you wish to request an accounting, you should contact the privacy officer under the contact information listed at the end of this Notice.





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Health Care Assistance Program  
1400 South Loop 336 West  
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HCAP#: \_\_\_\_\_

- It is my responsibility to contact all medical providers immediately and notify them of my HCAP coverage. Claims not submitted within **95 days** will become my responsibility for payment.
- I am responsible for instructing all medical providers where to submit medical claims, as indicated on my HCAP card. **I understand that I cannot send medical bills to the HCAP office, and that only medical providers must do this.**
- In the event of receiving a medical bill, it is my responsibility to contact the medical provider and instruct their staff to submit medical claims to the HCAP office as indicated on my HCAP card.
- I understand that medical claims received by HCAP will be processed adhering to District and State procedures and guidelines.
- I understand that HCAP is not responsible for any action a medical provider might take prior to, or following, the processing of claims by the HCAP office. This includes **balance billing, incorrect billing, rebilling, billing errors, refusal to see client, etc.**

**I acknowledge that I have read and fully understand my Bill-Pay Client Responsibilities listed above.**

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**Client Signature**

**Date**



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**BILL PAY FORMULARIO DE RESPONSABILIDAD DEL CLIENTE**

HCAP#: \_\_\_\_\_

- Es mi responsabilidad contactar a todos los proveedores médicos inmediatamente y notificarles sobre mi cobertura con HCAP. Facturas que no sean recibidas dentro de **95 días** se convertirán en mi responsabilidad de pago.
- Soy responsable de indicar a todos los proveedores médicos hacia dónde enviar facturas médicas, tal cual como se indica en mi tarjeta HCAP. **Entiendo que no puedo enviar facturas médicas a la oficina de HCAP, y que solo proveedores médicos pueden hacer esto.**
- En caso de recibir una factura médica, es mi responsabilidad contactar a dicho proveedor médico e indicarle a su equipo que las facturas médicas deben ser enviadas a la oficina de HCAP, tal cual como se indica en mi tarjeta HCAP.
- Entiendo que las facturas médicas recibidas por HCAP serán procesadas siguiendo procedimientos y pautas tanto del Distrito como del Estado.
- Entiendo que HCAP no es responsable de cualquier acción que un proveedor médico pueda tomar antes, o después, del procesamiento de facturas por parte de la oficina de HCAP. Esto incluye **facturación de saldo, facturación incorrecta, facturación múltiple, errores de facturación, rehusarse a prestar servicios, etc.**

**Reconozco que he leído y entiendo completamente mis responsabilidades listadas en este formulario.**

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**Firma del Cliente**

**Fecha**