Mason County Indigent Health Care Program
P O Box 1726
Mason, Texas 76856
Phone: 325-347-5556
Elizabeth Cano, CIHCP Coordinator

APPLICATION INSTRUCTIONS

The Mason County Indigent Health Care Program helps people pay for medical care on a short-term basis. Whether you are eligible depends on your income, what you own, where you live, help you receive and other items. Eligibility guidelines are set by the Texas Department of State Health Services.

To submit an application, fill out the attached forms and submit with all requested documentation. You must provide your own copies of the documentation. If you have any questions, you may call us at (325) 347-5556. Applications may be picked up in our office between 8:00 a.m. – 4:00 p.m., Monday through Thursday or 8:00 a.m. to 12:00 p.m., Friday. Completed applications may be returned to us by mail or delivered in person.

Once a **completed** application is received, a decision regarding your eligibility will be made within 14 days. Our office will notify you by mail of the decision. We ask that you wait to call our office regarding your application until the 14 day period has passed. **If your application is submitted and it is incomplete, it will be returned to you by mail with a request for additional information. We will not review incomplete applications for eligibility.**

You may be asked to apply for assistance through other program(s) before our department can determine your eligibility status. If you are asked to apply for assistance through other program(s) or you have applied but are awaiting an answer, your application may be held until you are determined to be ineligible for the other assistance program(s).

After turning in a completed application, **YOU MUST** report any household changes within 14 business days of the change. Examples of changes that require reporting are: address, income, employment, resources, number of people living in the home and any information from other assistance programs.

Required Documents for Application Process

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

You must provide your own copies. All pages/documentation must be completed. Incomplete applications will not be accepted.

- ☐ Application Packet (complete pages 3-14)
- ☐ Social Security Cards for all Household Members
- ☐ Texas Driver's License or Texas Identification card
- ☐ Birth Certificate/Permanent Residence Card/Certificate of Naturalization (not needed if providing a Texas DL or Texas ID Card)
- ☐ Passport (not needed if providing Texas DL or Texas ID card)
- ☐ Proof of Residence (examples: lease or rental agreement, mortgage information or tax assessor information).
- ☐ Child Support Court Order
- ☐ Checking/Savings Account Statements for the last 95 days
- ☐ Federal Income Tax Return (current year, including if claimed as dependent on another's return)
  Verification of any Retirement Plans, Payments or Funds
- ☐ Verification of benefits of Adult Medicaid, TANF or Food Stamps (award or denial letter)
- ☐ Verification of Children's Medicaid (for anyone in immediate household)
- ☐ Automobile Registration/Title
- ☐ Current Balance Owed on Vehicle

Please ✓ each applicable box or place an ✗ where information does not pertain to your case.

Note: You may be asked to provide additional information during the application process.

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.: _____

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.

Supplemental Application Information

Name: _____ **Date of Birth:** _____/_____/_____

What is your primary health concern at this time?

_____

_____

Please list all other ongoing health issues or diagnoses:

_____

_____

Are you currently unable to work due to a medical condition? Yes _____ No _____
If so, explain:

_____

_____

Do you have a disability that is expected to last longer than 12 months? _____

Do you have unpaid medical bills for the past 95 days? _____

Have you applied for Social Security Benefits? _____ If so, when? _____

Have you applied for Medicaid Benefits? _____ If so, when? _____

Is your medical diagnosis the result of a motor vehicle accident, crime or work related injury?
Yes _____ No _____ If yes, please explain:

_____

_____

Please list all medications that you are currently taking:

Medication	Reason for Medication	Daily Dosage

_____ _____

Applicant Signature **Date**

Employment Verification Form

Name: _____ **Date of Birth:** _____/_____/_____

☐ I have not been employed for_____ (months/years)

Reason for unemployment:

_____

_____

☐ Check this box if applicant has NEVER worked in the USA and sign and date the bottom of this form.

Current Employer: _____
Supervisor: _____
Company Address: _____
Telephone: _____

☐ Full Time
☐ Part Time

Hire Date: _____/____/____ Hourly Wage: _____ Hours Worked Weekly: _____

Pay Period: _____ Weekly _____ Bi-Weekly _____ Monthly

Please check all that apply:

☐ Insurance offered by company
☐ Insurance not offered by company
☐ Insurance accepted by employee
☐ Insurance declined by employee

_____ _____
Supervisor Signature **Date**

_____ _____
Employee/Applicant Signature **Date**

Spouse - Employment Verification Form

Name: _____ **Date of Birth:** _____/_____/_____

☐ I have not been employed for_____ (months/years)

Reason for unemployment:

_____

_____

☐ Check this box if applicant has NEVER worked in the USA and sign and date the bottom of this form.

Current Employer: _____
Supervisor: _____
Company Address: _____
Telephone: _____

☐ Full Time
☐ Part Time

Hire Date: _____/____/____ Hourly Wage: _____ Hours Worked Weekly: _____

Pay Period: _____ Weekly _____ Bi-Weekly _____ Monthly

Please check all that apply:

☐ Insurance offered by company
☐ Insurance not offered by company
☐ Insurance accepted by employee
☐ Insurance declined by employee

_____ _____
Supervisor Signature **Date**

_____ _____
Employee/Spouse Signature **Date**

Self-Employment Verification Form

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

☐ Check this box if you are not self employed

Individual Employer (and/or) Contract Employer:

_____

Address: _____

Telephone: _____

Tax ID Number: _____

☐ Full Time
☐ Part Time

Hours Worked Weekly: _____ Hourly Pay: _____

_____ _____

Individual Employer (and/or) Contract Employer Signature **Date**

_____ _____

Employee/Applicant Signature **Date**

Affidavit of Assets, Income and Resources
(Form Must Be Notarized)

This affidavit is made by me, _____ for the purpose of
(Applicant – Print Name)

informing the Mason County Indigent Program that I **DO** have access to the assets, income or resources listed below, either in the United States or any foreign countries.

Please Check the Items that you **DO** have access to:

- ☐ Ownership of any property in the U.S. or any foreign country
- ☐ Businesses in the U.S. or foreign countries
- ☐ Retirement plans or payments in the U.S. or foreign countries
- ☐ Vehicles
- ☐ U.S. banking accounts (checking, savings, IRA,etc.)
- ☐ Foreign banking accounts (checking, savings, IRA, etc.)
- ☐ Medical benefits in the U.S. or foreign countries (private insurance, Medicaid, Medicare, etc.)

I understand that if I fail to report any of the above, I will be held responsible for payment of any medical services that I may have received under the Mason County Indigent Health Care Program and I will be subject to prosecution under the Texas Penal Code.

STOP: DO NOT SIGN UNTIL YOU ARE IN FRONT OF NOTARY

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

_____
Applicant (Print Name)

_____ _____
Applicant Signature Date

Subscribed and sworn to (affirmed) before me this _____ day of _____, _____
(Day) (Month) (Year)

at _____. Notary Public in and for the State of Texas.
(Place of Notary)

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

_____
Notary Signature

Management Verification Statement

This form must be completed by any person helping to support the applicant. Please complete all information request below. An incomplete form will not be accepted.

Applicant's Name: _____ **Date of Birth:** ____/____/____

What is your relation to the applicant? _____

Does the applicant live with you? _____ How long? _____

If so, does the applicant pay rent? _____ How much? _____
Utilities? _____ How much? _____
Phone? _____ How much? _____

Have you paid any bills for this applicants? If so, state the bill, the amount, to who it is paid and the date:

_____

Have you ___ loaned or ___ given (check one) any money to the applicant? ____Yes ____ No

How much? _____ When? _____ Why? _____

Does the applicant purchase food separately from you? _____ Yes _____ No

Is the applicant working? _____ Yes _____ No Where? _____

Have you assisted the applicant in any way, other than bills? If so, please state how:

_____

_____

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this form and determine of eligibility for the applicant is committing a crime, which can be punished under Federal law, State law or both.

_____
Printed Name of Supporting Person

_____ _____
Signature of Supporting Person **Date**

Mason County Indigent Health Care Fraud Policy

Definition

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

Procedure

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

1. The MCIHCP staff shall investigate all cases of suspected fraud and collect and document evidence.

2. Upon a finding of fraud, the client shall be administratively ineligible from MCIHCP as follows:

First Offense:	24 months from the date fraud was discovered
Second Offense:	36 months from the date fraud was discovered
Third Offense:	48 months from the date fraud was discovered

3. The MCIHCP staff shall contact the client who is suspected of fraud by sending a certified letter informing the client of the withdrawal of eligibility and explaining the allegations. If the client disputes the allegations, the client will be allowed to submit applicable supporting documents/verifications for further consideration.

4. If the dispute remains unresolved, the MCIHCP staff shall schedule an administrative hearing to allow the client to defend himself by confronting any adverse witness and by presenting his own argument and evidence. The MCIHCP staff must disclose any evidence used to prove its case to the client so he has the opportunity to dispute it. The administrative hearing will be conducted by the Mason County Judge with the Coordinator of the MCIHCP present. The administrative hearing shall be held at the office of the Mason County Judge during normal business hours. The client shall be given thirty (30) days written notice of the date of administrative hearing. The burden of proof lies with the MCIHCP. If the client does not appear at the administrative hearing, the MCIHCP Coordinator may proceed with presentation of the MCIHCP's case only if proof of notice is present. The Mason County Judge will make a final decision within ninety (90) days of the hearing.

Consequence of Fraud

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

- shall reimburse Mason County for the cost of benefits the client was ineligible to receive;
- shall be administratively ineligible for MCIHCP benefits in accordance with the MCIHCP policies and procedures; and
- may be subject to prosecution under the Texas Penal Code.

_____ ____/____/____

Applicant (Print Name) **Date of Birth**

_____ _____

Signature **Date**

Consent to Obtain and Release Information

Applicant: _____ **SSN:** _____
Spouse: _____ **SSN:** _____

I am a member of a household applying for health care assistance from the Mason County Indigent Health Care Program. I understand that in order to determine this household's eligibility or continued eligibility, it is necessary for the Mason County Indigent Health Care Coordinator to verify all earnings and other information.

I authorize any relative, lawyer, employer, landlord, banker, postal savings official, insurance company, fraternal order, government agency, Texas Department of Health and Human Services, Social Security Administration, charitable organization or other person or entity having information about me or my circumstances to furnish such information to a representative of the Mason County Indigent Health Care Program for the purpose of making a determination of whether I meet the eligibility requirements for the Indigent Health Care Program.

I also give permission for any providers treating me to release my medical records to the Mason County Indigent Health Care Program for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment by the Mason County Indigent Health Care Program.

I authorize Mason County Indigent Health Care Program to release information in my application to persons and entities named above for the purpose of verifying all earnings and other information and to make a determination of my eligibility for the Mason County Indigent Health Care Program.

I understand that as part of the provision of healthcare services, Mason County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

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 this document. I consent to the use and disclosure, by Mason County Indigent Health Care Program, of my medical and health information and/or protected health information as is stated in the Notice of Privacy Practices.

This authorization is effective for one (1) year from the date of signature below.

_____ _____
Applicant Signature **Date**

_____ _____
Spouse Signature **Date**

Mason County Indigent Health Care Program
Please Keep for Your Records

PO Box 1726
Mason, Texas 76856
Phone: 325-347-5556

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • 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.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

October 1, 2016

This Notice of Privacy Practices applies to the following organizations.

Mason County Indigent Health Care Program