

County Indigent Health Care Program (CIHCP)

WORKSHEET

Date Identifiable Form 100 Is Received in Office	Case Record Number	Type of Determination <input type="checkbox"/> Application <input type="checkbox"/> Review
Case Record Name (Last, First, Middle)	Case Record Action <input type="checkbox"/> Approved <input type="checkbox"/> Continued <input type="checkbox"/> Denied	Eligibility Effective Date (MM-DD-YYYY)
		Prior Eligibility Effective Dates (MM-DD-YYYY)

_____ Date

_____ Signature – Eligibility Determiner

ELIGIBILITY ITEMS

DOCUMENTATION

1. Form 100

- A. Is the Form 100 appropriately signed and dated by the applicant? Yes No
- B. Is the Form 100 appropriately signed and dated by the spouse, if the applicant is married and the spouse lives in the house?..... Yes No N/A
- C. Is information complete and consistent? Yes No

2. Household

- A. Who is applying for CIHCP? _____

- B. Does legal responsibility for support exist between the applicant(s) listed in 2A and any other person living in the house?..... Yes No
If Yes, between whom? _____

- C. Does any individual listed in 2A or 2B receive Medicaid?
 Yes No If Yes, who? _____
Disqualify the Medicaid recipient(s) listed in 2C and use Step 2 of the Budget Calculation on Page 3, if applicable.
- D. Is any individual listed in 2A or 2B potentially eligible to receive Medicaid?..... Yes No
ø If yes, who? _____
Use the Medicaid screening tool: www.yourtexasbenefits.com and refer to the CIHCP Handbook for application processing.
- E. Who are the members of the CIHCP household?

[Verify household if questionable.]

In the following questions 3 - 10, "CIHCP household member " refers to each individual listed in 2E above.

ELIGIBILITY ITEMS

DOCUMENTATION

3. Residence

A. Is each CIHCP household member a county resident?
 **Yes** **No**

B. Does each CIHCP household member plan to remain in the
 county? **Yes** **No**

[Verify residence if questionable.]

4. Resources *[Exempt all resources of the Medicaid recipients listed in 2C.]*

A. Does any CIHCP household member own the following?

Resource	Yes	No	Countable Value
1. Cash on Hand			
2. Certificates of Deposit			
3. Checking Accounts			
4. Insurance Settlements			
5. Lawsuit Settlements			
6. Livestock			
7. Lump Sum Payments			
8. Notes, Bonds, Stocks			
9. Prepaid Burial Insurance			
10. Real Estate (excluding homestead)			
11. Retirement (including IRAs)			
12. Savings Accounts			
13. Vehicles			
14. Other Resources			
15. TOTAL COUNTABLE RESOURCES <i>[This amount is not rounded.]</i>			\$

B. Has any CIHCP household member transferred a countable
 resource within 3 months before application? **Yes** **No**

*[Document regarding countable resources for the application month
 and the 3 months prior. Verify resources if questionable or if the
 countable value is close to the resource limit.]*

5. Income *[Exempt all income of the Medicaid recipients listed in 2C.]*

A. Does any CIHCP household member have terminated income
 in the application month or the 3 months prior? .. **Yes** **No**

B. Does any CIHCP household member have any other countable
 income in the application month or the 3 months prior?.....
 **Yes** **No**

*[Document and verify all countable income, including terminated
 income, for the application month and the 3 months prior.]*

ELIGIBILITY ITEMS

DOCUMENTATION

6. Budget Calculation

A. Determine the household's monthly total countable income.

Type of Income	Name of Member with Income	
<u>Earned Income (#1 through #7)</u>		
1. Monthly Gross Earned Income		
2. Standard Work-Related Expense	-	-
3. Subtotal (Line 1 minus Line 2)		
4. 1/3 of Line 3	-	-
5. Subtotal (Line 3 minus Line 4)		
6. Child / Incapacitated Adult Care	-	-
7. Countable Earned Income		
<u>Unearned Income (#8 through #17)</u>		
8. Alien Sponsor's Income		
9. Cash Gifts, Contributions, Prizes		
10. Child Support Payments		
11. Interest and Dividend Payments		
12. Retirement Benefit Payments		
13. Social Security Benefit Payments		
14. Unemployment Benefit Payments		
15. V. A. Benefit Payments		
16. Worker's Compensation Payments		
17. Other Unearned Income		
(Add Line 7 plus Lines 8 through 17.)		
18. TOTAL COUNTABLE INCOME	+	= \$

B. Complete 6B if any of the CIHCP applicants is a spouse, a legal parent, or a stepparent not receiving Medicaid.
If the household contains no Medicaid recipients, go to 6C.

1. Total countable Income from 6A, Line 18	\$
2. Deduction for the support of the Medicaid recipients listed in 2C (See Handbook, Section 2, Page 29.)	-\$
3. Deduction for legally obligated child support payments made by members of the household group.	\$
4. Net Countable Income (Line 1 minus Line 2)	\$

C. Compare the CIHCP Household's Net Countable Income to the CIHCP Monthly Income Standard.

1. NET COUNTABLE INCOME (from 6A, Line 18 or from 6B, Line 3) with cents rounded down	\$
2. CIHCP Monthly Income Standard for the CIHCP household (See Handbook, Section 2, Page 30.)	\$

If the Line 1 amount is equal to or less than the Line 2 amount, the CIHCP household is income eligible.

If the Line 1 amount is greater than the Line 2 amount, the CIHCP household is not income eligible.

