Presidio-Brewster County Indigent Healthcare Program
APPLICATION REQUIREMENTS
PLEASE MAKE SURE TO BRING ALL DOCUMENTS REQUIRED TO YOUR APPOINTMENT

The Presidio-Brewster County Indigent Health Care Program requires that the application be completely filled out and signed at the time of submission. Incomplete applications will be denied or returned to you. This also includes failure provide the requested documents to process your application.
Please make sure to read the entire documentation, and ask questions as needed to fully understand the requirements and your responsibilities.

PROOF OF IDENTIFICATION FOR EACH APPLICANT

- Valid Texas Driver's License/Texas ID Card/Resident Alien Card/Passport (Expired documents and ID cards will not be accepted)
- Social Security
- Applicant must be 18 years or older

PROOF OF RESIDENCE

- Applicant must be a resident of Brewster or Presidio County
- Voter's Registration Card with same address as your application
- Current Utility Bill showing the same address as your application (regardless of name on bill).

INCOME (Determine which of the following to your situation)

- Paycheck Stubs
    - Weekly=Eight (8)recent paycheck stubs
    - Bi-weekly=Four (4) recent paycheck stubs
    - Monthly= Two (2) recent paycheck stubs
- If paid in cash, you must bring a statement from your employer verifying your income for the most current two (2) months.
- If self-employed, bring current records or complete the self-employment form as directed.
- Current Social Security Award Letter for both spouses and any children receiving it.
- Current Child Support Statements or alimony (actual check or court ordered child support). If unable to provide, must submit divorce decree.
- Current verification for Workmen's Compensation medical benefits or denial of benefits
- Current proof of any fixed income, such as: widow's benefits, retirement, pension, divided payments, unemployment, etc.
- If the applicant is unable to work, they must provide a letter or documentation from their physician stating the inability to work and the duration or must be enrolled in the Texas Workforce Commission.

RESOURCES

- Bank Statements from checking, saving, business accounts.
- Verification of stocks, bonds, or retirement accounts
- Automobile registration or title for all vehicles in the household regardless of whose name the vehicle is in. (If you still owe money for the vehicle please submit most current statement that shows the current balance).

VERIFICATION OF OTHER ASSISTANCE

- Current award/denial letter from Medicaid, TANF, SSI, Housing and Food Stamps or any other assistance program (bring all pages of those that apply).
- Any assistance within the last three months from your local Social Services or charity organizations. (Examples: Community Action Committee, Fundraiser, etc.)

TEXAS
Health and Human Services

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Review	Date Form 100 is Requested/Issued	Date Identifiable Form100 is Received	Case Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)		Home Telephone No./Teléfono de la casa		Other Telephone No./Otro número de teléfono
Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Si es el caso, enumere los nombres que ha usado. ☐Yes/Si ☐No				
Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP
Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.				

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.** / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

Name (Last, First, Middle) Nombre (Apellido, primero, segundo)	Social Security Number (if available) Número de Seguro Social (si lo tiene a su disposición)	Sex Sexo Male/ Female Hombre/ Mujer	Date of Birth Fecha de nacimiento	What Relation to you? ¿Parentesco con usted?	Are you a sponsored alien? ¿Es usted un extranjero patrocinado?
				MYSELF Yo mismo	

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that 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."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

2. **What is your household's county and state of residence (where you make your permanent home)?**
¿En qué condado y en qué estado viven (tienen su hogar permanente) usted y las personas de la unidad familiar?

County/Condado _____ State/Estado _____

Do you plan to remain in this county and state?
¿Piensa quedarse en este condado y este estado? ☐Yes/Sí ☐No

3. **Living Arrangements/Vivienda**
Check all boxes that apply to your household./Marque todas las cajitas que se apliquen a su caso.

☐ **Own or paying for home**
Soy dueño de mi casa o la estoy comprando

☐ **Live in a house provided by someone else**
Vivo en una casa ajena

☐ **No permanent residence**
No tengo residencia permanente

☐ **Live with someone else**
Vivo con otra persona

☐ **Rent House/Apartment**
Rento una casa o apartamento

☐ **Jail**
Cárcel

4. **List your average monthly household expenses./**Enumere los gastos mensuales de la unidad familiar.

Rent/Mortgage/Renta/hipoteca.....$ _____

Utilities (gas, water, electric)/Servicios públicos (gas, agua, luz).....$ _____

Telephone/Teléfono.....$ _____

Transportation, such as gas, car payments, bus/Transportación, tal como gasolina, pagos del carro, autobús.....$ _____

Tax and Insurance on home per year/Impuesto y seguro anual de la casa.....$ _____

Other/Otro.....$ _____

Other/Otro.....$ _____

Other/Otro.....$ _____

Does anyone pay these household expenses for you?
¿Hay otra persona que paga estos gastos de la unidad familiar por usted?..... ☐ Yes/Sí ☐ No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

5. **Are you – or is anyone in your household – receiving ☐ TANF ☐ Food Stamp ☐ Medicaid benefits?**
¿Está usted o alguien de la unidad familiar recibiendo beneficios de TANF, estampillas para comida, y/o Medicaid?..... ☐ Yes/Sí ☐ No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

6. **Are you – or is anyone in your household – pregnant?**
¿Está usted o alguien de la unidad familiar embarazada?..... ☐ Yes/Sí ☐ No **If Yes, who?**
Si contesta "Sí," ¿ quién? _____

7. **Are you – or is anyone in your household – disabled?**
¿Está usted o alguien de la unidad familiar incapacitada?..... ☐ Yes/Sí ☐ No **If Yes, who?**
Si contesta "Sí," ¿ quién? _____

8. **Have you – or has anyone in your household – applied for SSI or SSDI?**
¿Alguna vez usted o alguien de la unidad familiar solicitó beneficios de SSI o SSDI?..... ☐ Yes/Sí ☐ No

If Yes, who applied and when?
Si contesta "Sí," quién los solicitó y cuando? _____

9. **Do you – or does anyone in your household – have unpaid health care bills from the last three months?**
¿Tiene usted o alguien de la unidad familiar cuentas médicas sin pagar de los últimos tres meses?..... ☐ Yes/Sí ☐ No

If Yes, which months?
Si contesta "Sí," ¿Cuáles meses? _____

10. **Do you – or does anyone in your household – have health care coverage (Medicare, health insurance, V. A., Tricare, etc.)?**
¿Tiene usted o alguien de la unidad familiar la cobertura médica (Medicare, seguro médico, V. A., Tricare, etc.)?..... ☐ Yes/Sí ☐ No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

11. **How much money do you have? For example, on your person, in your home, in bank accounts, or other locations?**
¿Cuánto dinero tiene usted; por ejemplo, en el bolsillo, en la casa, en las cuentas bancarias, o en otros lugares?..... $

12. **How many cars, trucks, or other vehicles do you – and anyone in your household -- have? List the year, make, and model in the chart below./**¿Cuántos carros, camionetas u otros vehículos tienen usted y las personas de la unidad familiar? Anote el año, la marca, y el modelo en la tabla a continuación.

	Year/Año	Make and Model/Marca y Modelo
1.		
2.		

	Year/Año	Make and Model/Marca y Modelo
3.		
4.		

13. **Do you – or does anyone in your household – own or pay for a home, lot, land, or other things?**
¿Tiene o paga usted o alguien de la unidad familiar una casa, un lote, un terreno, u otros bienes?..... ☐ Yes/Sí ☐ No

14. **Did you – or did anyone in your household – sell, trade, or give away any cash or property during the last three months?**
Durante los últimos tres meses, ¿traspasó, vendió o regaló usted o alguien de la unidad familiar dinero o alguna propiedad?..... ☐ Yes/Sí ☐ No

15. **Have you – or has anyone in your household – worked in the last three months?**
¿Ha trabajado usted o alguien de la unidad familiar en los últimos tres meses?..... ☐ Yes/Sí ☐ No **If Yes, who?**
Si contesta "Si," ¿quien? _____

16. **List all of your household's income below. Be sure to 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./**Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	Name of agency, person, or employer who provides the money Nombre del patrón, la persona o la agencia que paga el dinero	Amount received Cantidad recibida	How often received? (daily, weekly, every two weeks, twice a month, monthly?) ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, dos veces al mes, una vez al mes?)

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 re-certification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas.

Me comprometo a dar al personal que verifica la elegibilidad y al condado toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad.

Me comprometo a avisar, dentro de los 14 días, de cualquier cambio de:

- Ingresos
- Recursos
- Número de personas que viven conmigo
- Dirección
- Solicitud de SSI, TANF, o Medicaid o la entrega de cualquiera de estas.

Me han dicho y comprendo que esta solicitud será considerada sin discriminación por raza, color, religión, credo, origen nacional, edad, sexo, discapacidad, ni afiliación política; que puedo pedir una revisión de la decisión que se haga acerca de mi solicitud de asistencia o recertificación para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier acción que afecte la entrega o la terminación de asistencia de atención médica.

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.

Comprendo que al firmar esta solicitud, doy al condado el derecho a recuperar de cualquier tercero el costo de los servicios médicos proporcionados por el condado. Me comprometo a dar al condado la información necesaria para identificar y localizar cualquier otro fuente de pagos por mis servicios médicos.

Me han dicho y comprendo que si dejo de cumplir con las obligaciones especificadas en ésta podría considerarse como una retención intencional de información y podría dar lugar a la recuperación de pérdidas por medio de la devolución de pagos o por medio de la presentación de cargos criminales en mi contra.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.
ANTES DE FIRMAR, ASEGÚRESE DE QUE CADA RESPUESTA SEA COMPLETA Y CORRECTA.

Signature – Applicant / Firma – Solicitante	Date / Fecha	Signature – Spouse / Firma – Esposo o Esposa	Date / Fecha

If the applicant is married and his/her spouse is a household member, the spouse may also sign and date this Form 100 even if the spouse is a disqualified household member. Si el/la solicitante está casado/a y su esposo o esposa vive en la misma casa, el cónyuge también puede firmar que su esposo o esposa también firme esta Forma 100, aunque no tenga derecho de recibir asistencia.

Signature - Person Who Helped Complete This Application / Date Firma - Persona que ayudó a llenar esta solicitud / Fecha	Signature - Applicant's Representative / Date Firma – Representante del solicitante / Fecha	Signature – Witness (if signed with "X") / Date Firma – Testigo (si firma con "X") / Fecha

Address (Street, City, State, ZIP) and telephone number of anyone who helped complete this Form 100/Dirección (Calle, Ciudad, Estado, ZIP) y teléfono de la persona que ayudó a llenar esta Forma 100

APPLICATION FOR HEALTH CARE ASSISTANCE

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:

Where You Live and Plan To Continue Living
Possible Proof: Mail that you received at your address; school records; voting records; property tax, rent or mortgage receipts; Texas driver's license; other official identification.

What You Own and What It Is Worth
Possible Proof: Property tax appraisals, estimates from car dealers, ads selling similar items, statements from real estate agents, bank statements.

Your Income
Possible Proof: Pay check stubs, pay checks, W-2 tax forms or income tax returns, sales records, statements from employers, award letters, legal documents, statements from persons giving you money.

Other Health Care Coverage
Possible Proof: Award or claim letters, insurance policies, court documents, other legal papers.

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of 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, if you have answered all the questions on the application, and if you 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.

SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

El Programa de Atención Médica para Indigentes del Condado (CIHCP) ayuda a la gente a pagar los servicios médicos que necesita. La elegibilidad para esta ayuda depende de los ingresos del solicitante, sus posesiones, el lugar donde vive, otra ayuda que recibe o que podría recibir, y otras consideraciones. Asegúrese de:

1.) Poner su nombre y dirección;
2.) Firmar y fechar la tercera página de la solicitud; y
3.) Conteste tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o échela al correo, hoy mismo aun si no ha podido contestar todas las preguntas.

SUS RESPONSABILIDADES

Puede que le pidan pruebas de lo que escriba en su solicitud o de lo que diga en su entrevista. Si necesita ayuda para obtener las pruebas, la persona que le haga la entrevista le puede ayudar. Estos son algunos ejemplos de información que puede que tenga que probar y de documentos que le puede servir de prueba:

El Lugar Donde Vive O Donde Tiene Su Hogar Permanente
Posibles Pruebas: Correo que recibió en esa dirección; expedientes de de la escuela; registros de votante; recibos de impuestos, renta o hipoteca; la licencia para manejar de Tejas; otra identificación oficial.

Las Posesiones Que Tiene Y Cuanto Vale Cada Una
Posibles Pruebas: El avalúo para impuestos sobre la propiedad, avalúos hechos por vendedores de carros, anuncios de la venta de artículos parecidos, declaraciones de agentes que venden propiedades, estado de cuentas del banco.

Los Ingresos Que Tiene
Posibles Pruebas: Talones del cheque de paga, cheque de paga, comprobante de salaries e impuestos (Forma W-2), declaración de impuesto federal, el historial de ventas, declaraciones de empleadores, carta de concesión, documentos legales, declaraciones de personas que le dan dinero.

Otra Cobertura Para Gastos Médicos
Posibles Pruebas: Cartas de reclamación o de concesión, pólizas de seguros, papeles de la corte u otros documentos legales.

Si tiene a su disposición los números de seguro social, debe darlos. La información sobre el sexo (Hombre/Mujer) es voluntaria. Esta información no afectará su elegibilidad.

Debe dar información sobre seguros médicos y de cualquier tercero que tenga la responsabilidad de pagar los servicios médicos pagados por el condado en beneficio de usted y miembros de la unidad familiar. Al firmar y presentar esta solicitud, usted se compromete a darle al condado el derecho de recuperar el costo de servicios de un tercero.

Pueden pedirle que solicite Medicaid, Asistencia Temporal a Familias Necesitadad (TANF), o Seguridad de Ingreso Suplemental (SSI). Si le han pedido que solicite beneficios de alguno de estos programas o si usted ya los solicitó y está esperando la respuesta, su solicitud de CIHCP puede ser detenida hasta que decidan que no es elegible para los programas mencionados. Si no es elegible para estos programas, si ha contestado todas las preguntas de la solicitud, y si ha dado todos los comprobantes que piden, ya pueden procesar su solicitud. Entonces, el CIHCP tiene un plazo de 14 dias para determinar su elegibilidad.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 dias cualquier cambio de dirección, ingreso, recursos, el número de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.

PRESIDIO-BREWSTER COUNTY INDIGENT HEALTHCARE PROGRAM
CONSENT TO OBTAIN AND RELEASE INFORMATION
CONSENTIMIENTO PARA OBTENER Y PARA LANZAR LA INFORMACIÓN

Applicant Name/Nombre de Aplicante: _____ SSN: _____

Spouse Name/Nombre de Esposo/Esposa:_____ SSN: _____

I am a member of a household applying for healthcare assistance from the Presidio-Brewster County Indigent Healthcare Program. I understand that in order to determine this household's eligibility or continued eligibility, it is necessary for the Presidio-Brewster County Indigent Healthcare Program to verify all earnings and other information.
Yo soy un miembro de la casa aplicando por asistencia de La Programa de Indigente del Condado de Presidio-Brewster. Yo entiendo que para que puedan determdeterminer casa califica para la programa o ayuda continuada, es necesario que La Programa de Indigente del Condado de Presidio-Brewster verifique ingresos y otra información.

I authorize the Indigent Healthcare Program to run a credit history and personal data search report for the purpose of making a preliminary determination of whether I meet the eligibility requirements for the Indigent Healthcare Program. I also understand that any approval will be conditional based on the information reviewed in my report.
Yo autorizo a la Programa de Indigente del Condado de Presidio-Brewster que verifiquen reports de crédito, y información personal para propósito de hacer una determinación de mi elegibiladad para La Programa de Indigente del Condado Presidio-Brewster. Entiendo que cualquier elegibiladad será condicional basado en la información revisada en mi reporte.

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 Presidio-Brewster County Indigent Healthcare Program for the purpose of making a determination of whether I meet the eligibility requirements for the Indigent Healthcare program.
Yo autorizo familiars, abogados, patrones, propietarios, banqueros, oficiales de ahorros postales, compañías de aseguransa. Orden fraternal, agencia de gobierno, el Departmento de Salud de Tejas, Administración de Seguro Social, organización de Caridad, o otra persona o entidad que tenga información de mí o mi circunstancia que den información a un representante de La Programa de Indigente del Condado de Presidio-Brewster para que hagan una determinación en mi caso de elegibilidad para la programa.

I agree to sign a written authorization permitting my physician(s) and other healthcare providers and healthcare entities to release my health information to the Presidio-Brewster County Indigent Healthcare for the purpose of making a determination of whether I meet the eligibility requirements for the Indigent Healthcare Program.
Yo voy a firmar una autorización escrita dando permiso a mí(s) doctor(es) medico(s) y otros abastecedores de cuidado medico u entiddes que den información a La Programa de Indigente del Condado de Presidio-Brewster para que puedan hacer una determinación en mi caso de elegibilidad para la programa.

I authorize the Presidio-Brewster County Indigent Healthcare department to release information in my application to the persons and entities names above for the purpose of verifying all earnings and other information and to make a determination of my eligibility for the Indigent Healthcare Program.
Yo autorizo que el departmento de La Programa de Indigente del Condado De Presidio-Brewster de información de mi aplicaciónde mi aplicación a las personas o enlistadas para el propósito de verificar todos ingresos y otra información y hacer una determiniación en mi caso sobre elegibilidad para la programa.

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 application and determination of eligibility is committing a crime, which can be punished under Federal Law, State Law or both.
Yo entiendo que cualquier persona que con conocimiento miente o falsifica información o consigue a alguien que lo haga en el proceso de completer esta aplicación a en el proceso de elegibiladad esta cometiendo un crimen, que puede ser castigada bajo Ley Federal, Ley de Estado, o los dos.

_____ _____
Signature of Applicant/*Firma de Aplicante* Date/*Fecha*

_____ _____
Signature of Applicant's Spouse/*Firma de Esposo/Esposa* Date/*Fecha*

_____ _____
Witness: Signature of Counselor/Testigo:Firma de Consejero Date/*Fecha*

PRESIDIO-BREWSTER COUNTY INDIGENT HEALTHCARE PROGRAM
ELIGIBILITY OFFICE AND PHYSICIAN'S CLINIC
CLINICA DEL MEDICO

BEHAVORIAL GUIDELINES
PAUTAS DE COMPORTAMIENTO

- ALL applicant's and qualified clients are required to comply with all State and County policies and guidelines to receive services through the Presidio-Brewster County Indigent Healthcare Program.
- *Todos los solicitantes y clientes calificados deben cumplir con todas las polizas y pautas estatales del condado para recibir servicios a traves del Programa de Cuidado de Salud Indigente del Condado de Presidio-Brewster*

- ALL applicants and qualified clients are required to comply with behavioral guidelines established by the State of Texas and apply to your Primary Care Physicians office and any specialist's offices they are referred to.
- *Todos los solicitantes y clients calificados estan obligados a cumplir con las pautas de comportamiento establecidas por el Estado de Texas y aplicar a su oficina de Primary Care Physicians y a las oficinas de cualquier especialista a los que se les hace referencia.*

- ALL applicants and qualified clients who are rude and display disruptive or abusive languages and behavior will not be seen. Our personnel will be protected from dangerous situations; physical or combative confrontations are grounds for immediate termination from the Indigent Healthcare Program.
- *No se veran a los solicitantes y clientes calificados que sean groseros y muestren lenguajes y comportamientos disruptivos o abusivos. Nuestra voluntad personal estara protegida de situaciones peligrosas; las confrontaciones fisicas o combativas son motive para la terminacion inmediata del Programa de Atencion Medica Indigente.*

- ALL qualified clients are expected to comply with the medical regime proposed by the assigned Primary Care Physician's office or by the Specialist Office of whom they were referred. Referred additional testing, such as lab, radiology procedures or other specialist referrals, should be completed within one week of their last primary care physician's visit. We cannot properly treat without testing results. Qualified clients will be terminated from the program for repeated non-compliance.
- *Se espera que todos los clients calificados cumplan con el regimen medico propuesto por la Oficina del Medico de Atencion Primaria asignada o por la Oficina de Especialistas de quien fueron referidos. Las pruebas adicionales referidas, como el alboratorio, los procedimientos de radiologia u otras dervivaciones especializadas, deben completarse una semana despues de la visita de su medico de atencion primaria. No Podemos tartar adecuadamente sin los resultados de las pruebas. Los clients calificados seran despedidos del programa por incumplimiento repetido.*

- No qualified clients shall receive any medications without periodic primary care physician evaluation (six months evaluation).
- *Ningun cliente calificado recibira ningun medicamento sin evaluacion periodica del medico de atencion primaria(evaluacion de sies meses).*

- Clients will be terminated from the Indigent Healthcare Program for illicit drug usage and continued alcohol abuse, if not currently and actively participating in a supervised rehab program.
- *Los clients seran despedidos del Programa de Cuidado de salud de Indigent por el uso ilicito de Drogas y el abuso continuo de alcohol, si no participant actualmente y activamente en un programa de rehabilitacion supervisado.*

- ALL qualified clients are expected to give all Physicians, Primary Care or Specialists, at least 24 hours advance notice to cancellation of an appointment, if the client is unable to keep the appointment. The client will be terminated from the Indigent Healthcare Program for repeated failure to keep scheduled appointments.
- *Se espera que todos los clients calificados notifiquen a todos los medicos, atencion primaria o especialistas con lo menos 24 horas de anticipacion a la cancelacion de una cita, si el cliente no puede cumplir la cita. El cliente sera despedido del Programa de Atencion Medica de Indigent por fallas repetidas en al realizacion de citas programadas.*

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES:
HE LEIDO Y ENTIENDO TODAS LAS PAUTAS ANTERIORES:

_____ _____

Applicant's Signature/*Firme de Solicitante* Date/*Fecha*

_____

Printed Name of Applicant/*Nombre en molde del Solicitante*

PRESIDIO-BREWSTER COUNTY INDIGENT HEALTHCARE PROGRAM
SUPPLEMENTAL APPLICATION INFORMATION

1. Briefly explain your current illness:
   Brevemente explique sus necesidades sobre su enfermedad:

   _____

   _____

   _____

2. Have you applied for Social Security Benefits? ☐YES ☐NO
   Ha aplicado por beneficios de Seguro Social? If Yes, When? _____

3. Do you have a bank account? ☐YES ☐NO
   Tiene una cuenta en el banco?

4. What is your marital status? ☐COMMON LAW ☐DIVORCED ☐MARRIED
   Cual es su estado civil? ☐WIDOW/WIDOWER ☐SINGLE ☐SEPERATED

5. Do you pay child care/handicapped adult care costs? ☐YES ☐NO
   Usted paga por el cuidado de ninos o cuiadado de una persona incapacitada?

   If yes, please list each dependent:

NAME/NOMBRE	AGE/EDAD	MONTHLY AMOUNT PAID/CANTIDAD POR MES

_____
Printed Name of Applicant/Nombre Imprecado de Aplicante

_____
Signature of Applicant/Firma de Aplicante

_____
Date/Fecha

P B C I H P

Presidio-Brewster County Indigent Healthcare Program
Big Bend Regional Hospital District

Fraud Policy/Poliza de Fraude

I, _____ attest that the statements I have made in my application and interviews, including my answers to all questions, are true and correct to the best of my knowledge and belief.
Yo,_____atestiguo de que las declaraciones que hice en mi solicitud y entrevista, incluyendo mis respuestas a todas las preguntas, son ciertas y correctas al major de mi conocimiento y creencia.

I agree to give staff and the Big Bend Regional Hospital District any information necessary to prove statements about my eligibility.
Accepto dar informacion al personal de eligibilidad y al Big Bend Regional Hospital District cualquier informacion necesaria para probar declaraciones sobre mi eligibilidad.

I agree to report any of the following changes within 14 days:
Estoy de acuerdo en reporter cualquiera de los siguientes cambios:

-Address/*Direccion*
-Household Members/*Los miembros del hogar*
-Property/*Propiedades*
-Income/*Ingresos*
-Application for/or receipt of SSI, TANF, or Medicaid/*Solicitud de SSI, TANF o Medicaid*

-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 criminal charges against me.
-He sido informado/a y entiendo que al no cumplir con las obligaciones establecidas sera considerado retencion de informacion intencional y puede resultar en la recuperacion de cualquier perdida mediante pago o presentando cargos civiles y penales contra mi.

(If a change occurs that makes you ineligible and you fail to report the change as required, you may be held responsible for payment of any health care services you receive after you become ineligible and/or you may be subject to prosecution under the Texas Penal Code.)
(Si ocurre un cambio que lo haga ineligible y usted no reporta el cambio como es requerido, usted puede ser considerado/a responsable de cualquier atencion medica resivida despues de ser ineligible y puede ser subjeto/a a procesamiento bajo el Codigo Penal de Texas)

_____ _____
Applicant Signature/*Firma de Solicitante* Date/*Fecha*

_____ _____
Caseworker/*Firma de Asistente Social* Date/*Fecha*

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your Initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☒ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☒ My benefit or payment amounts from date _____ to date _____
5. ☒ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Landlord Verification

PBCIHP
Presidio - Brewster County
Indigent Healthcare Program

DATE
CASEWORKER
OFFICE ADDRESS AND TELEPHONE NO. WITH AREA CODE

NAME OF CLIENT	CASE NO.
ADDRESS (STREET. CITY, STATE AND ZIP CODE)	

The above named person reports renting the listed address from you as their primary residence. To correctly evaluate the household situation, the department needs your assistance.

Please complete the information requested on the back of this letter and return it no later than _____.
Date

I hereby give my permission to release the information requested on this form.

_____ _____
Applicant Signature Date

Landlord Verification

This form must be completed by the client's landlord or representative

1. Date tenant moved in? ....._____

2. How many people live in the house or apartment?....._____

3. List the names of all the people who live in the house or apartment. List their employer, if known:

Name of Person	Working?		Employer
	Yes	No	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

4. Questions about the rent payment:

AMOUNT OF RENT	TENENAT'S PORTION OF RENT	PERSON MAKING PAYMENT?

HOW OFTEN PAID?

☐WEEKLY ☐EVERY TWO WEEKS ☐TWICE A MONTH ☐MONTHLY

METHOD OF PAYMENT?

☐CASH ☐CHECK ☐MONEY ORDER ☐OTHER (EXPLAIN): _____

IS TENANT CURRENT IN PAYING THE RENT?

☐YES ☐NO – IF NO, WHEN WAS THE LAST MONTH RENT WAS PAID? _____

WHAT IS THE TOTAL AMOUNT OF PAST DUE RENT? _____

Notes from landlord:

Please provide the tenant's complete residential address?

STREET ADDRESS	APT. NO.	CITY	ZIP CODE

_____ _____ _____

LANDLORD/REPRESENATIVE NAME (PRINTED) LANDLORD/REPRESENTAIVE SIGNATURE DATE

LANDLORD/REPRESENTATIVE ADDRESS	TELEPHONE NO. WITH AREA CODE

Alpine Office
105 W. Holland Avenue
P.O. Box 1019
Alpine, Texas 79831
(432) 837-7051
(432) 837-3261-Fax

Big Bend Regional Hospital District

Presidio Office
602 W. O'Reilly Street
P.O. Box 3044
Presidio, Texas 79845
(432) 229-2151
(432) 229-2161-Fax

Date/Fecha_____

I, _____, authorize _____
Applicant's Name — Name of Bank or Credit Union

to forward the requested bank statements to **Big Bend Regional Hospital District**, for the purpose of the Presidio-Brewster County Indigent Healthcare Program.

Yo, _____, autorizo _____
Nombre de Solicitantes — Nombre de Banco o Cooperativa de Credito

para enviar los extractos bancarios solicitados a **Big Bend Regional Hospital District**, a los fines del Programa de Indigent Heathcare del Condado de Presidio-Brewster.

_____ _____
Applicant's Signature/Firma de Solicitantes — Date/Fecha

_____
Account Number/Numero de Cuenta

Alpine Office
105 W. Holland Avenue
P.O. Box 1019
Alpine, Texas 79831
(432) 837-7051
(432) 837-3261-Fax

Big Bend Regional Hospital District

Presidio Office
602 W. O'Reilly Street
P.O. Box 3044
Presidio, Texas 79845
(432) 229-2151
(432) 229-2161-Fax

Banks

Alpine Community Credit Union
432-837-5156

WesTex Community Credit Union
432-837-9839

West Texas National Bank
432-837-3375

Trans Pecos Banks
432-837-0094

Ft. Davis State Bank (Alpine)
432-837-1888

Marfa National Bank
432-729-4344

Ft. Davis State Bank (Presidio)
432-229-5000

1st Presidio Bank
432-229-5000

Property Tax Offices

Brewster County Tax Office
432-837-2214

Presidio County Tax Office
432-229-3963

Utilities

City of Alpine
432-837-0047

City of Presidio
432-229-3517

City of Marfa
432-729-4315

Additional

Big Bend Community Action Committee (Alpine)
432-729-4908

Big Bend Community Action Committee (Presidio)
432-299-0480

Texas Workforce Commission (Local)
432-837-9800

Neighborhood Center of Alpine
432-837-2142