Community Action Health Center- Outreach & Enrollment
REQUIRED Documents

1. Proof of Benefits

- **SNAP** - SNAP Eligibility Letter
- **CHIP Perinatal** – CHIP Perinatal benefits card
- **Medicaid for Pregnant Women** - "YTB" card (Medicaid card)
- **Insurance Cards** - Private Pay, Medicare and Medicaid
- **WIC** - Use one of the following:
  - Verification of Certification Letter
  - Printed WIC-Approved Shopping List
  - Recent WIC Purchase Receipt with remaining balance

AND/OR (As many of the following apply):

2. Proof of Income: (Most current consecutive check stubs, If you are paid)

- Weekly - 2 check stubs
- Bi-Weekly - 2 check stubs
- Monthly - 1 check stub
- Child Support - CIN # or Award Letter
- Social Security - Award Letter
- Unemployed - Unemployment Award Letter (TWC)
- Self Employed- Statement of declaration for 3 months or Income tax return

3. Identification: (For Head of Household and Spouse/Significant Other)

- Current Picture ID ** If ID is expired, a birth certificate along with expired ID will be accepted.
- Driver's License or State ID

4. Proof of Residency: (Any one of the following is accepted)

- Valid Texas Driver License
- Current voter registration
- Rent or utility receipts for one month prior to the month of application
- Motor vehicle registration
- School records
- Medical cards or other similar benefit cards
- Property tax receipt
- Mail addressed to the applicant, their spouse, or children if they live together

5. For any children under 18, any one of the following is accepted:

- Birth Certificate
- Baptismal Record
- School Record

Important Information

- Your application will not be accepted if all required documents are not attached.
- If you are dropping off an application, please allow 3 business days from the date of drop off for your application to be processed.

If you have any questions please call the enrollment office

Outreach & Enrollment Contact Information						
Alice	**Beeville**	**Kingsville**	**Falfurrias**	**Sinton**	**Benavides**	**Mathis**
700 Flournoy Rd. Tel: 361-664-1417 **Laura Smithwick** Ext.2140 **Teresa Rivera** Ext. 2145	301 S.Hillside Drive Tel:361-362-0307 **Lesley De Leon** Ext. 2206	1311 E. General Cavazos Suite C Tel:361-592-3237 **Irene Martinez** Ext. 2519	1302 S. St. Mary's Tel: 361-325-9404 **Irene Martinez** Ext. 2519	621 E. Sinton Tel: 361-364-4486 **Lesley de Leon** Ext. 2206	115 W. Main St. Tel: 361-256-3663 **Laura Smithwick** Ext.2145 **Teresa Rivera** Ext. 2145	502 E. San Patricio Ave. Tel: 361-547-4121 **Lesley De Leon** Ext. 2206

TEXAS Health and Human Services

Form 3029
September 2024

PHC and Title V MCH FFS

Application For Program Benefits

Use this application to apply to the Primary Health Care (PHC) Program and the Title V Maternal & Child Health Fee-For- Service (Title V MCH FFS) Program.

Section I. Applicant Information

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

Name of Person	Sex	Date of Birth	Race or Ethnicity

Home Address	City	County	State	ZIP Code

Primary Area Code and Phone No.	Secondary Area Code and Phone No.

Email Address

Communication Preferences

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

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

Preferred Spoken Language ☐ English ☐ Spanish ☐ Other: _____

Preferred Written Language ☐ English ☐ Spanish ☐ Other: _____

Section II. Household Members

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

Number of Household Members: _____

*Primary Health Care Program **(PHC)**, Title V Child Health & Dental **(TV CHD)** or Title V Prenatal Medical & Dental **(TV PMD)**

Name (Last, First, Middle)	**Date of Birth**	**Sex**	**Race or Ethnicity**	**Relationship to Applicant**	**Program Applying For?** (*PHC, TV CHD, TV PMD or NA)	**Enrolled in a Health Insurance Plan?**
				Applicant		○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No

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

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

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

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

If yes, provide a detailed explanation:

Section III. Screening for PHC Adjunctive Eligibility

Are you applying to the PHC program? ◯ Yes ◯ No* (If you checked no, continue with Section IV.)

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

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

*If a PHC applicant provides proof of active enrollment in one of these listed programs, verify current enrollment status by calling TMHP or accessing TexMedConnect. If confirmed, then adjunctive eligibility may be granted for the PHC program and Section IV will not need to be completed. Record the verification in Section VI notes.

Section IV. Household Income

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

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

Notes:

Section V. Acknowledgement

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I agree to report all changes in income, family composition, residence, current address, employment and all types of health care coverage or benefits no later than 30 days after I become aware of the change. I understand that giving false information could result in disqualification and repayment.

Privacy Notification

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

_____
Initials

Acknowledgment

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

Statement of Release of Information

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

Coverage Attestation

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

_____ _____
Applicant Signature **Date**

Section VI. Contractor Eligibility Determination

All questions must be answered by eligibility staff:

1. Texas resident ..... ◯ Yes ◯ No
2. Total calculated household income ..... _____
3. Household federal poverty level (FPL)% ..... _____
4. Documentation of income* ..... ◯ Yes ◯ No
5. Documentation of residency* ..... ◯ Yes ◯ No
6. Documentation of date of birth* (if applying for Title V CHD) ..... ◯ Yes ◯ No
7. If applicant is applying for **PHC Adjunctive Eligibility**, were benefits verified through Texas Medicaid & health care Partnership (TMHP)? ..... ◯ N/A ◯ Yes ◯ No
8. Is applicant applying for **PHC Supplemental Benefits**?..... ◯ N/A ◯ Yes ◯ No

   If yes, list the PHC services applicant does not have primary coverage for and will be eligible for:

9. Is the applicant(s) potentially eligible for:
   - Medicaid? ..... ◯ Yes ◯ No
   - Medicaid for Pregnant Women? ..... ◯ Yes ◯ No
   - CHIP? ..... ◯ Yes ◯ No
   - CHIP Perinatal? ..... ◯ Yes ◯ No

***If an applicant qualifies for program benefits and has an immediate medical or dental need, but does not have the required documentation, then Presumptive Eligibility must be given.**

***Applicants currently enrolled in a health care plan but do not have any dental coverage, and would otherwise qualify for program benefits, will be eligible for Title V Dental benefits.**

Notes:

Section VII. Contractor Eligibility Certification

Eligibility Effective Date: _____

Name of Client	Program Eligibility (PHC, TV CHD, TV PMD or NA)	Type of Eligibility Granted (Eligible or Presumptive Eligibility)	Type of Determination (New or Recertification)	Copay Amount

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

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

This form must be kept with the client's record and should not be submitted to HHSC state office.

Eligible Clients must receive:
Form 3012, Notice of Eligibility

Presumptive Eligibility Clients must receive:
Form 3045, Presumptive Eligibility Notice

Applicants who did not qualify for program benefits must receive:
Form 3047, Notice of Ineligibility

TEXAS
Health and Human Services

Form 1065
May 2019-E

Breast and Cervical Cancer Services (BCCS) Program or Family Planning Program (FPP)

Eligibility Application

Section I. Applicant Information

This form can be used to apply for BCCS or FPP.

Name (Last, First, Middle)	Sex ◯ Male ◯ Female	Date of Birth	Race/Ethnicity
Email Address	Primary Area Code and Phone No.	Alternate Area Code and Phone No.	
Home Address (Street, Apt. or P.O. Box)	City	County	State / ZIP Code

Communication Preferences

Please contact me by: ☐ Mail ☐ Phone ☐ Email:

Preferred language: ☐ English ☐ Spanish ☐ Other

Section II. Applicant Health Care Information

I have comprehensive health care coverage. This includes Medicaid, Medicare, Children's Health Insurance Program (CHIP), Veterans Benefits, TRICARE, private insurance, etc. (If yes, an authorized program representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.) ◯Yes ◯No

Check all benefits that you receive:

- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Women, Infants and Children (WIC) Program
- ☐ Healthy Texas Women (HTW) Program
- ☐ CHIP Perinatal
- ☐ Medicaid for Pregnant Women
- ☐ Other

Section III. Household Information

Number of people in the household. _____ This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s), if applicable.

Name (Last, First, Middle)	Date of Birth	Sex	Race/Ethnicity	Relationship

Household Income Information

Name of person receiving money	Name of employer/person who provides the money	Amount of money received per month

Type of Deduction	Deduction Amount

Section II. Applicant Health Care Information

I have read the Rights and Responsibilities statements.

Privacy Notification

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

Important Information for Former Military Service Members

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

Acknowledgment

_____
Please Initial

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

Coverage Attestation

_____
Please Initial

I attest that, to the best of my knowledge, I have no other coverage than what is listed in Section II, Applicant Health Care Information. I authorize the program to bill the coverage sources listed for any services provided.

Statement of Release of Information

_____
Please Initial

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

_____ _____
Applicant Signature Date

Section V. Provider Eligibility Certification (completed by provider)

1. Texas resident ..... ◯Yes ◯No
2. Total monthly household income..... _____
3. Household federal poverty level (FPL)..... _____ %
4. Proof of income..... ◯Yes ◯Waived
5. Adjunctively eligible..... ◯Yes ◯No ◯N/A
6. Full eligibility met..... ◯Yes ◯No
7. Full eligibility met date..... _____
8. Is the person eligible for the following program (s)?

   Eligibility effective date:..... _____

   a. BCCS..... ◯Yes ◯No ◯N/A

   b. HHSC FPP..... ◯Yes ◯No ◯N/A

Name of Agency

_____
Signature – Agency Staff Member

_____
Date

COMMUNITY ACTION CORPORATION OF SOUTH TEXAS

Community Action Health Center
Outreach & Enrollment Registration Form

Applicant Name (Last, First, Middle and Maiden) Household Member #1	DOB	Date
☐ Jr. ☐ Sr. ☐ III ☐ IV		

Mailing Address (Street, City, State, Zip)	County:

Physical Address (Street, City, State, Zip)	County:

Home Phone	Cell Phone	Email:	How would you like us to contact you?
			☐ Home Phone ☐ Cell ☐ Mail ☐ Patient Portal ☐ Email ☐ Text Alerts

Social Security #	Sex:	Language:	US Citizen	Do you live in an area that provides Public Housing?	Homeless
	☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M	☐ English ☐ Spanish ☐ Other _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Marital Status	Ethnicity	Race
☐ Married ☐ Legally Separated ☐ Single ☐ Widowed ☐ Partner ☐ Divorced	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to report	☐ Asian ☐ White ☐ Native Hawaiian ☐ Multi-Race ☐ Black/African American ☐ Other ☐ American Indian/Alaskan Native ☐ Refuse to report

Emergency Contact Name	Phone	Relationship

Applicant Name (Last, First, Middle and Maiden) Household Member #2	DOB:	Date:
☐ Jr. ☐ Sr. ☐ III ☐ IV		

Mailing Address (Street, City, State, Zip)	County:

Physical Address (Street, City, State, Zip)	County:

Home Phone	Cell Phone	Email:	How would you like us to contact you?
			☐ Home Phone ☐ Cell ☐ Mail ☐ Patient Portal ☐ Email ☐ Text Alerts

Social Security #	Sex:	Language:	US Citizen	Do you live in an area that provides Public Housing?	Homeless
	☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M	☐ English ☐ Spanish ☐ Other _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Ethnicity	Race
☐ Married ☐ Legally Separated ☐ Single ☐ Widowed ☐ Partner ☐ Divorced	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to report	☐ Asian ☐ White ☐ Native Hawaiian ☐ Multi-Race ☐ Black/African American ☐ Other ☐ American Indian/Alaskan Native ☐ Refuse to report

Emergency Contact Name	Phone	Relationship

List the Health Center you want to choose as your Medical Home	List the Primary Care Provider you want to establish with

COMMUNITY ACTION CORPORATION OF SOUTH TEXAS

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES WITH PSYCHIATRIC ADDENDUM AND PATIENT AND HEALTH CENTER RIGHTS AND RESPONSIBILITIES

I hereby acknowledge that I have received the Notice of Privacy Practices with Psychiatry Addendum and the Patient and Health Center Rights and Responsibilities.

Name of Patient or Representative: _____

Representative's Relationship to Patient: _____

Signature: _____ **Date:** _____

Name of Patient or Representative: _____

Representative's Relationship to Patient: _____

Signature: _____ Date: _____

Community Action Health Centers
NOTICE OF PRIVACY PRACTICES WITH PSYCHIATRY ADDENDUM

Clients are provided a copy of this Notice of Privacy Practices at the time they sign the Center Patient and Health Center Rights and Responsibilities and upon request. A copy of this Notice of Privacy Practices is available in Spanish upon request.

To our Clients:

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice applies to all of the records of your care generated by this Center, whether made by the Center or an associated provider. Our policies on protecting your health information extend to all professional authorized persons who have a need to know to provide care to you. The policies apply to all areas of the Center including all Center staff, the front desk, billing and administration. It also applies to any entity or individual with whom we contract services, such as referral providers. Your other health care providers may have different policies regarding their use and disclosure of your health information created at their location.

YOUR PROTECTED HEALTH INFORMATION

As our patient, we create paper and electronic medical records and documents concerning you and your health, as well as the care and services we provide to you. We need this record to provide continuity of care and to comply with certain legal requirements. We are required by law to:

- Maintain the privacy of health information that identifies you (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you; and
- Follow the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

DISCLOSURE AT YOU REQUEST. We may disclose health information when requested by you. This disclosure at your request may require a written Authorization by you.

TREATMENT. We use information previously compiled about you to provide you with current or future health care treatment or services. Therefore, we may, and most likely will, disclose your information to doctors, nurses and other health care personnel who are involved in your care. We also may disclose health information about you to people outside the Center who may be involved in your healthcare after you leave the Center, such as nurses, social workers, family members, or clergy. We may also use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

PAYMENT. We may use and disclose medical information about you concerning services and procedures so they may be billed and collected from you, your insurance company or third party reimbursement entity such as Workers Compensation. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

OPERATIONAL USES. We may use and disclose medical information about you in order to operate the Center efficiently and make sure our patients receive quality care. We may also combine and analyze health information about many Center patients to decide what additional services the Center should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, students, volunteers and other Center personnel for review and learning purposes. Additionally, we may combine the health information we have with health information from other Centers to compare how we are doing and to see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

SIGN-IN SHEET. We may use and disclose health information about you by having you sign in when you arrive at the Center. We may also call out your name when you are ready to be seen.

APPOINTMENT AND PATIENT RECALL REMINDERS. We may use and disclose your health information to contact you to remind you regarding appointments or for medical care that you are to receive.

BUSINESS ASSOCIATES. Some of our functions are accomplished through contracted services provided by Business Associates. A Business Associate may include any individual or entity that receives your health information from us in the course of performing services for the Center. Such services may include, without limitation, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

DISASTER RELIEF. In an emergency, we may disclose information about you to an entity assisting in disaster relief so that your family can be notified about your condition, status and location.

HEALTH-RELATED PRODUCTS AND SERVICES. We may use and disclose health information to tell you about our health-related products or services that may be of interest to you.

FAMILY, FRIENDS, OR OTHER INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another individual involved in or responsible for your health care about your location at the Center, your general condition, or in the event of your death. We may also disclose information to someone who helps arrange for payment for your care. If you are able and available to agree or to object, we will give you the opportunity to agree or object prior to making these disclosures, although we may disclose this information in the case of a disaster even over your objection if we believe it is necessary to respond to the disaster or emergency situation. If you are unable or unavailable to agree or object, we will use our best judgment in any communication with your family, personal representative, and other involved individuals.

RESEARCH. We may participate in research concerning the use of certain treatment protocols that have proper governmental and Center approval. In that case, we would secure your informed consent that will identify all aspects of your involvement, risks and benefits and possible disclosures.

REQUIRED BY LAW. We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use and disclose your health information to persons who need to know when necessary to prevent a serious threat to either your health or the health and safety of others.

CHANGE OF OWNERSHIP. In the event that the Center is sold or merged with another organization, your health information/medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another Center, medical group, physician or other healthcare provider.

HEALTH OVERSIGHT ACTIVITIES. We may disclose your health information to a health oversight agency for activities authorized by federal, state or local laws and regulations. These oversight activities include, for example, audits, inspections, licensure reviews, investigations into illegal conduct, compliance with other laws and regulations. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

INMATES. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the institution or law enforcement official, if the disclosure is necessary (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.

ORGAN AND TISSUE DONATION. If you are an organ donor, we may disclose medical information to organizations that handle organ procurement **or** organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

PUBLIC HEALTH REPORTING. We may report your health information as required by law or by your authorization concerning certain health conditions to prevent or control disease, injury or disability, births and deaths, child or elder abuse or neglect, reactions to medications or products, recalls of products, and notice of exposure to a condition.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE. We may disclose your health information to law enforcement, social services, or other government agencies authorized to receive the report if we have reason to believe that you are a victim of abuse, neglect, or domestic violence.

LAWSUITS AND DISPUTES. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a subpoena, court subpoena or court order, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request (which may include written notice to you) and you have not objected, or to obtain an order protecting the information requested.

LAW ENFORCEMENT. We may release your health information to law enforcement officials in response to a court order, subpoena, warrant, summons or similar process to identify or locate a suspect, witness, or missing person, concerning a victim of a crime, about a death we believe may involve criminal actions, criminal conduct in progress, crimes on Center premises, or emergency situations to report a crime or details of a crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS. We may release your health information to a coroner or medical examiner or funeral directors as necessary for them to carry out their duties.

MILITARY AND NATIONAL SECURITY. If you currently serve in the military or are a veteran, we may disclose your health information to the military upon proper request. We may also disclose your information to federal officials conducting national security and intelligence activities.

WORKERS' COMPENSATION. We may disclose your information if required by workers' compensation laws and other similar laws and regulations. These programs provide benefits for work-related injuries or illness.

SECURITY CLEARANCES. We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the Department of State who need access to that information for these purposes.

MULTIDISCIPLINARY PERSONNEL TEAMS. We may disclose health information to a state or local government agency or a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF HEALTH INFORMATION. In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in this Notice or Privacy Practices. For example, there are special restrictions on the use and/or disclosure of certain categories of health information such as: (a) AIDS treatment information and HIV tests results; (b) treatment for mental health conditions and psychotherapy notes; (c) alcohol, drug abuse and chemical dependency treatment information; and/or (d) genetic information, are all subject to special restrictions. In addition, Government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of patient information for purposes unrelated to the program.

YOUR PRIVACY RIGHTS

You have the right to:

INSPECT AND COPY YOUR HEALTH INFORMATION. You may ask to review and get a copy of health information about you that the Center keeps for as long as the Center has it. Center may charge a fee for any copies that you ask for. Please make this request in writing to the Center's **Privacy Contact**. We may deny your request to inspect and copy in specific circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. The Center will comply with the outcome of the review.

AMEND YOUR HEALTH INFORMATION, IF YOU FEEL IT IS WRONG OR NOT COMPLETE. You may request that we amend the health information the Center keeps. If the Center accepts your request to amend your health information, the change will become a permanent document in your health care record. Please make this request in writing to the Center's **Privacy Contact**. You must include a reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the health information kept by or for the Center;
3. Is not part or the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

REQUEST RESTRICTIONS. You may ask the Center not to use or disclose your health information. Your request must describe the specific limits you are requesting. The Center may deny your request. Please make this request in writing to the Center's **Privacy Contact**.

WE RESERVE THE RIGHT TO ACCEPT OR REJECT YOUR REQUEST. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We will notify you if we do not agree to a requested restriction. To request restrictions, you must submit a written request to the Center at the above address. In your request, you must state: (a) what information you want to limit; (b) whether you want to limit its use, disclosure or both; and (c) to whom you want the limits to apply; for example, no disclosures to your spouse.

RIGHT TO RESTRICT DISCLOSURE FOR SERVICES PAID BY YOU IN FULL. You have the right to restrict the disclosure of your health information to a health plan if the health information pertains to health care services for which you paid in full directly to the Center and the disclosure is not otherwise required by law.

REQUEST A LIST OF DISCLOSURES WE HAVE MADE OF YOUR HEALTH INFORMATION. You can request a list of disclosures of your health information that the Center has made. This list will not include routine disclosures of your health information for treatment, payment, or business operations purposes described above. Please make this request in writing to the Center's **Privacy Contact**.

REQUEST CONFIDENTIAL COMMUNICATIONS FROM US. We will not disclose your health information except as described in this Notice. However, you may ask us to contact you by another means or at a different address or to limit the number or type of people who have access to your health information. Please make this request in writing to the Center's **Privacy Contact**.

RECEIVE A PAPER COPY OF THIS NOTICE FROM US. You may request a copy of this Notice at any time.

RIGHT TO NOTICE OF BREACH. You have the right to be notified if we or one of our Business Associates becomes aware of an improper disclosure of your health information.

YOUR RIGHT TO COMPLAIN

COMPLAINTS. If you believe that your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing, and all complaints will be investigated.

CHANGES TO THIS NOTICE

CHANGES TO THIS NOTICE. We reserve the right to change this Notice at any time. We will post a copy of the current notice in the Center with the effective date in the upper right hand corner of the first page. You may request a copy of the current notice each time that you visit the Center for services or by calling the Center and requesting that the current notice be sent to you in the mail.

PRIVACY CONTACT INFORMATION

If you have any questions about this Notice or wish to submit a request, please contact the Center's **Privacy Contact** at:
Compliance Officer
Address: P.O. Drawer 1820 Alice, TX 78333
Telephone: 361-664-0145 ext. 2002

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will stop the uses and disclosures allowed by that permission, except to the extent that we have already acted in reliance on your permission. For example, we are unable to take back any disclosures we have already made with your permission.

PARTICIPATION IN A HEALTH INFORMATION EXCHANGE (HIE)

As part of our health care operations, we intend to participate in an electronic HIE, which is a local or regional arrangement of health care organizations and providers who have agreed to work with each other to facilitate access to health care information that may be relevant to your care. For example, if you are admitted to a facility on an emergency basis and cannot provide important information about your health condition, the HIE will allow participating providers access to your pertinent health information shared from your various providers so that they may be more quickly able to offer you appropriate treatment. When it is needed, ready access to your health information means better care for you. Once we begin participation in a HIE, we will retain health care information (including PHI) about our patients in a shared electronic medical record with other health care providers who also participate in the HIE.

We intend that your PHI be used responsibly by our organization as well as the organizations we are affiliated with such that data will be encrypted and stored within a secure network and if your PHI is transmitted, it will be done over a private secure network, with administrative, physical and technical safeguards in accordance with this Notice and the law.

If you choose not to participate in the electronic HIE, you will be given an opportunity to opt out of the HIE. If you later change your mind, you will be given an opportunity to opt back into the HIE.

"OPTING-OUT" OR "OPTING-BACK" INTO THE HEALTH INFORMATION EXCHANGE (HIE)

If you opt-out of the HIE, your health information will continue to be used in accordance with this Notice and the law, but will NOT be made available through the HIE, even in medical emergencies. Your choice for "opting-out" or "opting-back" into the HIE will have to have to be made by a written request. The necessary form to enable you to do so will be provided by the staff at any of our medical office practice sites upon your request.

NOTICE OF PRIVACY PRACTICES Psychiatry Addendum

THIS ADDENDUM NOTICE DESCRIBES HOW PSYCHIATRIC OR MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS ADDENDUM NOTICE IS PART OF THE "NOTICE OF PRIVACY PRACTICES" THAT APPLIES TO YOUR OTHER HEALTH INFORMATION. PLEASE REVIEW THIS ADDENDUM AND THE NOTICE OF PRIVACY PRACTICES CAREFULLY.

If you have any questions about this Notice, please contact the Center's Privacy Manager at: (361) 245-5154; or the Center's Chief Operating Officer at: (361) 664-0145.

CONFIDENTIALITY OF PSYCHIATRIC OR MENTAL HEALTH RECORDS

The confidentiality of your psychiatric or mental health records maintained by the Center gets special protection under federal and state laws. We may, however, disclose psychiatric or mental health information that identifies you without your Authorization in the following circumstances:

Disclosure at Your Request. We may disclose health information when requested by you. This disclosure at your request may require a written Authorization by you.
For Treatment. We may use your psychiatric/mental health information to provide you with medical treatment or services. We may disclose your psychiatric information to health care professionals outside this facility only if they are responsible for your physical or mental health.
For Payment. We may use or disclose your psychiatric/mental health information to substantiate or collect on a claim for mental health treatment or services you receive at the Center.
For Health Care Operations. We may use and disclose psychiatric/mental health information about you for our health care operations activities. These uses and disclosures are necessary to operate the Center efficiently and make sure that all of our patients receive quality care.

ADDITIONAL USES AND DISCLOSURES OF MENTAL HEALTH INFORMATION INCLUDE:

As Required by Law. We will disclose health information about you when required to do so by federal, state or local laws or regulations.

For Legal Proceedings and Disputes. If you are involved in a judicial or administrative legal proceeding (lawsuit or a dispute), we may disclose psychiatric/mental health information about you in response to a court or administrative order or when such disclosure is otherwise required or permitted by law. For example, we may disclose psychiatric or mental health information to courts, attorneys and court employees in the course of conservatorship, and certain other judicial or administrative proceedings. We may also disclose mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

For Research. We may disclose your psychiatric/mental health information to researchers who request it for approved medical research projects; however, such disclosures must be cleared through a special approval process before any information is disclosed to the researchers who will be required to safeguard the information they receive.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, we may notify emergency response personnel about a possible exposure to Acquired Immune Deficiency Syndrome ("AIDS") and/or the Human Immunodeficiency Virus ("HIV"). Any such disclosure, however, would only be to the extent required or permitted by federal, state or local laws and regulations.

To Law Enforcement. We may disclose your psychiatric/mental health information to law enforcement personnel in limited and specific circumstances. For example, we may disclose psychiatric information to law enforcement if your provider determines that there is a probability of imminent physical injury by a patient (to himself/herself or to another person). In addition, we may disclose your psychiatric/mental health information if a crime has been committed by a patient at the Center.

To Government Agencies. We may disclose your psychiatric/mental health information to notify the appropriate government agency when required or authorized by law (for example, if we believe that a patient has been the victim of abuse or neglect).

To Healthcare Oversight Agencies. We may disclose your psychiatric/mental health information to healthcare oversight agencies to ensure that we are meeting the standards of care and services and that we are complying with the applicable laws and regulations. We will only make this disclosure when required or authorized by law.

Special Categories of Health Information. In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in this Notice or Privacy Practices. For example, there are special restrictions on the use and/or disclosure of certain categories of health information. For example, (1) AIDS treatment information and HIV tests results; (2) treatment for mental health conditions and psychotherapy notes (*see* discussion, below); (3) alcohol, drug abuse and chemical dependency treatment information; and/or (4) genetic information, are all subject to special restrictions. In addition, Government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of patient information for purposes unrelated to the program.

Psychotherapy Notes. Psychotherapy notes are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.
Psychotherapy notes exclude: (a) medication prescription and monitoring; (b) counseling session start and stop times; (c) the modalities and frequencies of treatment furnished; (d) results of clinical tests; and (e) any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.[1] We may use or disclose your psychotherapy notes, for treatment, payment or healthcare operations, or:

1. for use by the originator of the notes;
2. in supervised mental health training programs for students, trainees, or practitioners;
3. by the Covered Entity to defend a legal action or other proceeding brought by the individual;
4. to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
5. for the health oversight of the originator of the psychotherapy note;
6. for use or disclosure to coroner or medical examiner to report a patient's death, and information related to the diagnosis and treatment of the patient's physical condition;
7. for use or disclosure necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
8. for use or disclosure to the Secretary of the U.S. Department of Health and Human Services ("HHS") in the course of an investigation; and/or
9. as required by law.

Generally, we will not tell anyone outside the Center that you are being treated by the Center for a psychiatric or mental health issue.

Other uses and disclosures of your psychiatric or mental health information not covered by this Notice of Privacy Practices, Psychiatric Addendum or the laws that apply to us will be made only with your written Authorization.

Please see the general Notice of Privacy Practices for information on revoking an Authorization for the Use or Disclosure of Health Information. Your rights regarding your health information outlined in the general Notice of Privacy Practices also apply to your psychiatric/ mental health information.

REVISED DATE - This Notice was revised on August 25, 2022.

Community Action Health Center

PATIENT AND HEALTH CENTER RIGHTS AND RESPONSIBILITIES

Welcome to the Health Center. Our Goal is to provide quality health care to people in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. The Health Center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read the Patient and Health Center Rights and Responsibilities, ask any questions you may have, before signing the acknowledgement.
Human Rights:

1. You have a right to be treated with respect regardless of race, color, creed, marital status, religion, sex (including gender harassment and harassment based on pregnancy, childbirth or related medical conditions), sexual orientation, national origin, limited english proficiency, ancestry, physical or mental handicap or disability, age, veteran status, political affiliation, or belief, or other grounds not permitted by applicable federal, state and local laws or regulations.

Payment For Services:

1. You are responsible for giving us accurate information about your present financial status and any changes in your financial status. We need this information to decide how much to charge you and/or so we can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.

2. You have a right to receive explanations of our bill. You must pay, or arrange to pay, all agreed fees for medical services, with the exception of dental services, which are provided on a prepaid basis. If you cannot pay right away, please let us know so we can provide care for you now and work out a payment plan.

3. Federal law prohibits us from denying you primary health care services which are medically necessary, solely because you cannot pay for these services.

4. If you omit information, fail or refuse to give information, or give false or misleading information about these matters you may be required to reimburse the State for the services rendered if you are found to be ineligible for services. You will report changes in your household/ family situation that affects eligibility during the certification period (changes in income, household/ family members, and residency).

5. You authorize release of all information, including but not limited to, income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to your household/ family or you.

6. You understand you may be asked by the Provider to provide proof of any of the information provided in this application.

7. Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Worker's Compensation benefits, must be reported to Provider. Benefits from health insurance may be considered the primary source of payment for health care received. You hereby assign to Provider any such benefits. You also assign payment for benefits and services received from and through Provider directly to the service providers.

8. You understand and agree that the program does not provide payment for inpatient care. You understand that you must make your own arrangements for hospital care and that you are responsible for the cost of the care.

Privacy:

1. You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached as "Notice of Privacy Rights." By signing the acknowledgement of receipt you are indicating that you have received this Notice. The Notice details the various rights granted to you by the Health Insurance Portability and Accountability Act.

2. With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Health Care:

1. You are responsible for providing us complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.

2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan (including risks) and expected outcome, if known, and information regarding Advance Directives. If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to a legally authorized person.

3. You are responsible for appropriate use of our services, which includes following our staff's instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. We may not be able to see you unless you have an appointment. If

you cannot follow the staff's instructions, please tell us so we can help you.

4. If you are an adult, you have a right to refuse treatment to the extent permitted by law and to be informed of the risks of refusing such care. You are responsible for the outcome of refusing treatment.

5. You have a right to health care and treatment that is reasonable for your condition and within our capability. You have a right to be transferred or referred to another facility for services that we cannot provide. But, we do not pay for services that you get somewhere else. The Health Center is not an emergency care facility. After hours coverage is available. Providers may be reached after hours by calling each Health center at:

Community Action School Based Health Center Mathis PH# 361-547-4121
Community Action Health Center Sinton PH# 361-364-4486
Community Action Pediatric Center Sinton PH# 361-364-4486
Community Action Health Center Beeville, Ste. 5, 6, 8, 15 PH# 361-362-0307
Community Action Health Center Kingsville PH# 361-592-3237
Community Action Health Center, Ste. 2A P H# 361-664-1417
Community Action Health Center Falfurrias, Suite A, B & D PH# 361-325-9404
Community Action Health Center Duval PH# 361-256-3663
Community Action Health Center Mobile Clinic # 2 (TAMUK) PH# 361-239-0600

6. If you are in pain, you have a right to receive an appropriate assessment and management, as necessary.

7. Some programs specify that you must be a bonafide resident of Texas or a dependent. You must physically live in Texas, maintain living quarters in Texas, and not claim to be a resident of another state or be a dependent of a bonafide Texas resident. You will be notified at time of enrollment if you are enrolled in a program with these requirements.

8. Some programs provide care through program- approved providers. You understand that, to receive benefits from such programs, treatment must be received through those program-approved providers.

9. You understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

10. You understand that you will receive written documentation concerning the services for which your household/ family or you are eligible or potentially eligible.

Health Center Rules:

1. You have a right to receive information on how to appropriately use the Health Center's services. You are responsible for using the Health Center's services in an appropriate manner. If you have questions, please ask us.

2. You are responsible for the supervision of children you bring with you to the Health Center. You are responsible for their safety and the protection of clients and our property.

3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments you may be asked to meet with a representative of the health center to determine the reason for your missed appointments and whether you can continue as a patient of the Health Center.

4. You understand that, to maintain program eligibility, you will be required to apply for assistance at least every twelve months.

Complaints:

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Complaints may be filed with the Health Center manager. If you are not satisfied with the resolution of your complaint please file a Patient Concern Form with the Compliance Officer.

2. If you complain, we will not punish you for filing a complaint and we will continue to provide services.

3. You have the right to file a complaint regarding the handling of your application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332. Any services related discrimination allegations or complaints will be reported by the Health Center to the HHSC Civil Rights Office within 10 days.

Termination:

1. If we decide that we must stop treating you as a patient, you have a right to advance notice that explains the reason for the decision, and you will be given 30 days to find other health care services. We can decide to stop treating you immediately and without notice if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the Termination of Patient and Provider/ Health Center Relationship policy.

Reasons for which we may stop seeing you include:
A) Failure to comply with our rules, such as keeping scheduled appointments
B) Intentional failure to accurately report your financial status

C) Intentional failure to report accurate information concerning your health or illness
D) Intentional failure to follow the health care program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your provider, and/or
E) Creating a threat to the safety of the staff and/or other patients

2. If we have given you notice of termination of the patient and provider/ health center relationship, you have the right to appeal the decision to The Executive Director. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.