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 - 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.2140 **Teresa Rivera** Ext. 2145	502 E. San Patricio Ave. Tel: 361-547-4121 **Lesley De Leon** Ext. 2206

TEXAS Health and Human Services

PHC and Title V MCH FFS

Application For Program Benefits

Form 3029
September 2026

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 1 – Applicant Information

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

Last, First and Middle Name		Sex ◯ Male ◯ Female	Date of Birth	Race or Ethnicity
Home Street Address or P.O. Box	City	State	ZIP Code	County
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: _____

Service Members

Have you, or any other applicants, ever served in the U.S. Armed Forces or Texas Military Forces, regardless of length of service or type of discharge? ◯ Yes ◯ No ◯ Prefer Not to Answer

Important Information for Former Military Services Members

If you have served in the military, you may be entitled to additional services. Visit the Texas Veterans Portal at veterans.portal.texas.gov for more information.

Important Information for Former Female Military Service Members

If you are an adult woman who served in the military, you may be entitled to more services. Visit the TVC's Women Veterans Program website at tvc.texas.gov/women and the Texas Veterans Portal at veterans.portal.texas.gov.

Section 2 – Household Members

List all Household Members. Household members include the applicant and anyone who lives with them and they are legally responsible for. Children younger than 18 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 and Dental **(TV CHD)** or Title V Prenatal Medical and Dental **(TV PMD)**

Name Last, First, Middle	**Date of Birth**	**Sex** Male or Female	**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

Do any household members have special circumstances that may affect their inclusion in the household? ◯ Yes ◯ No

Provide a detailed explanation if yes.

Section 3 – Screening for PHC Adjunctive Eligibility

Are you applying to the PHC program? ◯ Yes ◯ No* Continue with Section 4 if you checked no.

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

☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Women, Infants, and Children (WIC) Program

☐ Medicaid for Pregnant Women

☐ Children's Medicaid*

☐ None of these

*If a PHC applicant provides proof of active enrollment in one of these listed programs, verify current enrollment status by calling Texas Medicaid & Healthcare Partnership (TMHP) or accessing TexMedConnect. If confirmed, adjunctive eligibility may be granted for the PHC program and Section 4 does not need to be completed. Record the verification in Section 6 notes.

Section 4 – 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 Applicant Who Provides Money**	**Type of Income**	**Gross Amount Received**	**How Often Received** weekly, bi-weekly, bi-monthly or monthly	**Monthly Income Total**
				Gross Household Monthly Income:	
				Allowable Deductions:	
				Adjusted Gross Household Monthly Income:	

Notes:

Section 5 – Applicant 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 all necessary information 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 on 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 this application is a legal document. 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. If I am approved to receive program services, I will be held accountable for complying with program policies. This includes 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 on this application. I authorize the program to bill the coverage sources listed for any services provided. Initials

Applicant Signature **Date**

Section 6 – Eligibility Determination Completed by Provider

All questions must be answered by eligibility staff:

1. Texas resident ..... ◯ Yes ◯ No
2. Total adjusted gross monthly 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 through Adjunctive Eligibility**, were benefits verified? If so, documentation of enrollment must be included. ..... ◯ Not Applicable ◯ Yes ◯ No
8. Is applicant applying for **PHC Supplemental Benefits**?..... ◯ Not Applicable ◯ Yes ◯ No

   List the PHC services applicant does not have primary coverage for, if yes:

9. Is the applicant(s) potentially eligible for:

   Children's Medicaid or CHIP? ..... ◯ Yes ◯ No

   Medicaid for Pregnant Women or CHIP-P? ..... ◯ Yes ◯ No

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

If an applicant is enrolled in a health care plan but has no dental coverage and otherwise qualifies for program benefits, they are eligible for Title V dental benefits. Specify in the space below.

Notes:

Section 7 – Eligibility Certification Completed by Provider

Eligibility Effective Date: _____

Name of Client	**Program Eligibility** PHC, TV CHD, TV PMD or NA	**Type of Eligibility Granted** Eligible or Presumptive Eligibility	**Copay Amount**

By signing below, I attest that the above listed applicants have met program eligibility requirements. I have notified all applicants who appear potentially eligible for Medicaid for Pregnant Women, Children's Medicaid, CHIP, CHIP Perinatal or other related state programs that they must also apply for these programs on YourTexasBenefits.com.

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

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

- **Eligible Clients must receive** Form 3012, Verification 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.

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

Revised 08/2025

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 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
Javelina Health Clinic PH# 361-239-0600
Community Action Health Center Kenedy PH # 361-666-5632

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.

Revised: 08-2025

Community Action Corporation of South Texas (Health Center)
NOTICE OF PRIVACY PRACTICES WITH PSYCHIATRY ADDENDUM

Patients are provided a copy of this Notice of Privacy Practices at the time they sign the Health 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 Patients:

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 the Health Center, whether made by the Health Center or an associated clinician. 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 Health Center including all Health Center staff, the front desk, billing and administration. It also applies to any entity or individual with whom we contract services, such as referral clinicians. Your other health care clinicians 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 are currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

The following categories describe different ways that we may use and disclose health information. The following category is an explanation. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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.

TREATMENT. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, students and other health care personnel who are involved in your care. We also may disclose health information about you to people outside the Health Center who may be involved in your healthcare after you leave the Health 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. Javelina Health Clinic patient health information may be disclosed to Texas A & M University Kingsville for reimbursement and payment purposes. 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 health information about you in order to operate the Health Center efficiently and make sure our patients receive quality care. We may also combine and analyze health information about many Health Center patients to decide what additional services the Health 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 Health Center personnel for review and learning purposes. Additionally, we may combine the health information we have with health information from other Health 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. Additionally, we may combine the health information we have with health information from other Health 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.

We participate in an Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and other health care clinicians who accept Original Medicare (Parts A & B) and work together to coordinate patients' overall health care. Medicare will share certain information about Medicare patients' personal health with the health center. If you do not want Medicare to share your health information with your healthcare clinicians, you can call 1-800-MEDICARE (1-800-633-4227) and tell the representative you do not want your personal healthcare information shared among the healthcare clinicians trying to serve your healthcare needs.

SIGN-IN SHEET. We may use and disclose health information about you by having you sign in when you arrive at the Health 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 health 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 Health 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 Health 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. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will be approved through this research approval process. However, we may also disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the Health Center.

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 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.

CHANGE OF OWNERSHIP. In the event that the Health 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 Health Center, medical group, physician or other healthcare clinician.

SPECIAL SITUATIONS

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 health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ 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 disclose your health information about you for public health activities. We will only make this disclosure if you agree or when required or authorized by law. These activities generally include the following: (a) to prevent or control disease, injury or disability; (b) to report births and deaths; (c) to report the abuse or neglect of children, elders and dependent adults; abuse or neglect, (e) to notify people of recalls of products they may be using; and (f) to notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE. We may disclose your health information to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure when required or authorized by law.

LAWSUITS AND DISPUTES. If you are involved in a lawsuit or dispute, we may disclose your health information to the extent expressly authorized by a court or administrative order. We may also disclose health information about you in response to a subpoena, 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.

In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your substance abuse treatment records unless a court order requires us, or you give us your written permission.

LAW ENFORCEMENT. We may release your health information to law enforcement officials in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect fugitive, material witness, or missing person; (c) about a victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement (d) about a death we believe may be the result of criminal conduct (e) about criminal conduct at the Health Center; or (f) in emergency situations to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

However, in many situations we are prohibited from sharing, and will not share, your health information for investigations or legal actions concerning reproductive health care access and services where that care is lawful as provided. For example, the law prohibits us from using or disclosing your reproductive health care information in many instances to: (a) respond to investigation requests, court orders, or subpoenas seeking information about or imposing liability on any person for seeking, obtaining, providing, or facilitating lawfully provided reproductive health care; or (b) identify any person that is subject to a criminal, civil, or administrative investigation or legal action, including any in law enforcement investigations, criminal prosecutions, family law proceedings, or state licensure proceedings, for seeking, obtaining, providing, or facilitating lawfully provided reproductive health care. Some examples of seeking, obtaining, providing, or facilitating reproductive health care include: using reproductive health care; performing, furnishing, or paying for reproductive health care; providing information about reproductive health care; arranging, insuring, administering, providing coverage for, approving, or counseling about reproductive health care; or attempting any of these activities.

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

MILITARY AND VETERANS. If you are a member of the armed forces, we may release health information about you as required by military authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES.

We may release health information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

WORKERS' COMPENSATION. We may disclose health information about you for workers' compensation and/or similar programs. 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, and/or (e) reproductive health care 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.

REPRODUCTIVE HEALTH CARE INFORMATION USES AND DISCLOSURES REQURING ATTESTATION

By law, if we collect, receive, or maintain health information that is potentially related to your reproductive health care, in some cases we must obtain an attestation from health information recipients that they will not use or share that information for a purpose prohibited by law. The following situations require attestation:

- Health Oversight Activities
  We may share your reproductive health care information for health oversight agency audits or inspections, civil or criminal investigations or proceedings, or licensure actions.
- Judicial and Administrative Proceedings
  We may share your reproductive health care information in response to a court or administrative order, subpoena, or discovery request.
- Law Enforcement Purposes
  We may share your reproductive health care information for law enforcement purposes, including in response to a court-ordered warrant or a law enforcement official's request for information about a victim of a crime.
- Coroners or Medical Examiners
  We may share your reproductive health care information in some situations to a coroner or medical examiner to identify a deceased person, determine cause of death, or other duties as authorized by law.

YOUR PRIVACY RIGHTS

You have the following rights regarding health information we maintain about you:

INSPECT AND COPY YOUR HEALTH INFORMATION. You may ask to review and get a copy of health information about you that the Health Center keeps for as long as the Health Center has it. We may charge a fee for any copies that you ask for. Please make this request in writing to the Health 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 Health Center will review your request and the denial. The person conducting the review will not be the person who denied your request. The Health Center will comply with the outcome of the review.

REQUEST RESTRICTIONS. You may ask the Health Center not to use or disclose your health information. Your request must describe the specific limits you are requesting. The Health Center may deny your request. Please make this request in writing to the Health 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 Health 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 Health Center and the disclosure is not otherwise required by law.

RIGHT TO AMEND . If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to your health information for as long as the information is kept by or for the Health Center. You must make your request to amend your health information, in writing, and submit it to the Health Center at the above address. 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 Health Center;
3. Is not part or the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

The law permits us to deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Even if the Health Center denies your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum

to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

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 Health Center has made. This list will not include routine disclosures of your health information for treatment, payment, or business operations purposes described above. To request this list or accounting of disclosures, you must submit your request in writing to the Health Center at the above address. Your request must state a time period that may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred

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 Health 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 Health 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 Health 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 Health Center for services or by calling the Health 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 Health 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 participate in an electronic HIE, which is a local or regional arrangement of health care organizations and clinicians 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 allows participating clinicians access to your pertinent health information shared from your various clinicians 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. We retain health care information (including PHI) about our patients in a shared electronic medical record with other health care clinicians 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 may opt out of the HIE by submitting the HIE Opt Out Request Form. The form will be provided by the staff at any of our medical office practice sites upon your request.

"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 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 Health Center's Privacy Manager at: (361) 245-5154; or the Health Center's Chief Operating Officer at: (361) 664-0145

CONFIDENTIALITY OF PSYCHIATRIC OR MENTAL HEALTH

The confidentiality of your psychiatric or mental health records maintained by the Health 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 healthcare you receive at the Health 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 Health 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 clinician 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 Health 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 clinician 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 Health Center that you are being treated by the Health 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 January 30, 2026