

DICKENS COUNTY, TEXAS—OFFICE OF INDIGENT HEALTH CARE SERVICES:

AFFIDAVIT REGARDING CHANGE OF INCOME/RESOURCES

AFFECTING ELIGIBILITY STATUS OF APPLICANT

My name is _____, Applicant. I am over the age of eighteen (18) years of age and competent to make this Affidavit.

I understand it is my responsibility to report any change in my income or resources might affect my eligibility status to the Office of the Dickens County Indigent Health Care Services within 14 days after the date that the change actually occurs, including but not limited to the following matters:

WHEN I MOVE TO ANOTHER PERMANENT RESIDENCE ADDRESS INSIDE THE COUNTY, I MUST REPORT THAT CHANGE AND PROVIDE MY NEW RESIDENCE ADDRESS.

WHEN I MOVE TO ANOTHER PERMANENT RESIDENCE ADDRESS OUTSIDE THE COUNTY, I MUST REPORT THAT CHANGE AND PROVIDE MY NEW RESIDENCE ADDRESS.

WHEN I CHANGE MY PRIMARY OR SECONDARY TELEPHONE NUMBERS, I MUST REPORT THAT CHANGE AND PROVIDE ANY NEW TELEPHONE NUMBERS.

IF I BECOME EMPLOYED ON ANY JOB, I MUST REPORT THAT CHANGE AND PROVIDE THE DATE OF EMPLOYMENT AND SALARY.

IF I BECOME UNEMPLOYED ON ANY JOB, I MUST REPORT THAT CHANGE AND PROVIDE THE EMPLOYMENT TERMINATION DATE.

IF I RECEIVE AN INCREASE IN SALARY OR WAGES FROM EMPLOYMENT, I MUST REPORT THAT CHANGE AND PROVIDE THE DATE OF THE PAY INCREASE AND THE PAY AMOUNT.

IF MY EMPLOYMENT HOURS INCREASE OR DECREASE PERMANENTLY, I MUST REPORT THAT CHANGE AND PROVIDE THE DATE OF THE CHANGE AND THE AMOUNT OF THE INCREASE OR DECREASE TO MY SALARY OR WAGES.

IF I REQUEST FINANCIAL ASSISTANCE BY FILING A CLAIM OR SUBMITTING DOCUMENTS FOR SOCIAL SECURITY BENEFITS (INCLUDING SSI, SOCIAL SECURITY DISABILITY, AND SURVIVOR'S BENEFITS), I MUST REPORT THAT CHANGE AND PROVIDE THE DATE OF THE APPLICATION, FILING, AND STATUS OF THE CLAIM.

IF I RECEIVE FINANCIAL ASSISTANCE FROM MEDICAID, SOCIAL SECURITY, SSI, SOCIAL SECURITY DISABILITY, SURVIVOR'S BENEFITS, UNEMPLOYMENT, OR WORKMAN'S COMPENSATION BENEFITS, I MUST REPORT THAT CHANGE AND PROVIDE THE DATE ANY SUCH BENEFIT IS RECEIVED AND THE AMOUNT OF BENEFIT.

IF I RECEIVE ANY CHANGE TO MY INCOME RECEIVE, REGARDLESS OF WHETHER IT IS EARNED OR UNEARNED INCOME, I MUST REPORT THAT CHANGE AND PROVIDE THE EFFECTIVE DATE OF THE INCOME CHANGE AND ITS AMOUNT.

IF A CHANGE OCCURS IN MY MARITAL STATUS (INCLUDING MARRIAGE, DIVORCE, OR SEPARATION), I MUST REPORT THAT CHANGE AND PROVIDE A DESCRIPTION OF THE NEW STATUS.

IF I REQUEST FINANCIAL ASSISTANCE BY FILING A CLAIM OR SUBMITTING DOCUMENTS FOR FOOD STAMPS, I MUST REPORT THAT CHANGE AND PROVIDE THE DATE OF THE APPLICATION, FILING, AND STATUS OF THE CLAIM.

IF MY FINANCIAL RESOURCES CHANGE BECAUSE I OBTAINED A CHECKING ACCOUNT, SAVINGS ACCOUNT, CERTIFICATE OF DEPOSIT, STOCK OR INVESTMENT SECURITY, BOND, REAL PROPERTY, SETTLEMENTS, OR OTHER FINANCIAL ACTIVITY, I MUST REPORT THAT CHANGE AND PROVIDE DOCUMENTS DESCRIBING THE ACTIVITY.

If I fail to timely report any such change to the office of the Dickens County Indigent Health Care Services, as herein described, I understand I may be subject to the following sanction:

I MAY BE DISQUALIFIED FROM PARTICIPATION IN THE DICKENS COUNTY INDIGENT HEALTH CARE SERVICES PROGRAM FOR (12) TWELVE MONTHS FOR THE FIRST VIOLATION, AND PERMANENTLY FOR THE SECOND VIOLATION.

I MAY BE REQUIRED TO REIMBURSE DICKENS COUNTY FOR THE BENEFITS RECEIVED DURING THE PERIOD OF MY INELIGIBILITY.

I MAY BE SUBJECT TO CIVIL LITIGATION FOR THE RECOVERY OF THE BENEFITS RECEIVED DURING THE PERIOD OF MY INELIGIBILITY AND ALL OTHER REMEDIES ALLOWED BY LAW.

I MAY BE SUBJECT TO CRIMINAL PROSECUTION.

I understand the terms, provisions, and sanctions of the Dickens County Indigent Health Care Services Program and agree to comply with its terms and provisions.

I have read and understand this Affidavit and the contents of this Affidavit are true and correct.

I have received a copy of this Affidavit upon signing it.

Signed on the _____ day of _____, 20____

Applicant: _____

Printed Name: _____

STATE OF TEXAS

COUNTY OF DICKENS

SWORN TO AND SUBSCRIBED to before me, the undersigned authority, on the _____ day of _____, 20____

Notary Public, State of Texas

NOTARY SEAL