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

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

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)	Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono

Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Si es el caso, enumere los nombres que ha usado.

☐Yes/Si ☐No

Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP

Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.

1. **On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.** / En la tabla a continuación, llene la primera linea con información acerca de usted mismo. Llene las lineas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

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

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

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

County/Condado _____ State/Estado _____

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

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

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

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

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

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

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

☐ **Jail**
Cárcel

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

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

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

Telephone/Teléfono.....$ _____

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

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

Other/Otro.....$ _____

Other/Otro.....$ _____

Other/Otro.....$ _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. **List all of your household's income below. Be sure to include the following: Government checks; money from training or work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support and unemployment./**Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; o pagos por desempleo.

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

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief.

I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility.

I agree to report any of the following changes within 14 days:

- **Income**
- **Resources**
- **Number of people who live with me**
- **Address**
- **Application for or receipt of SSI, TANF, or Medicaid**

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief; that I may request a review of the decision made on my application or re-certification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

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

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

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

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

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

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party. I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

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

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

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

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

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

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

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

APPLICATION FOR HEALTH CARE ASSISTANCE

The County Indigent Health Care Program (CIHCP) helps people pay for needed health care. Whether you can get this help depends on your income, what you own, where you live, other help you receive or could receive, and other items. Be sure to:

1.) Complete your name and address;
2.) Sign and date Page 3 of the application; and
3.) Answer as many questions as you can on this application.

Turn in or mail back your application today even if you cannot answer all the questions.

YOUR RESPONSIBILITIES

You may be asked to bring proof of what you write on your application or what you tell the person interviewing you. If you need help getting proof, the person interviewing you will help. Examples of some of the items you may be asked to prove and documents you can use for proof are:

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

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

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

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

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services paid by the county for yourself and members of your household. By signing and submitting this application, you are agreeing to give the county the right to recover the cost of health care services provided by the county from any third party.

You may be asked to apply for Medicaid, Temporary Assistance for Needy Families (TANF), or Supplemental Security Income (SSI) benefits. If you are asked to apply for one of these programs or have applied but are waiting for an answer, your CIHCP application may be pended until you are determined ineligible for the other program. If you are not eligible for these other programs, if you have answered all the questions on the application, and if you have given all the proof asked for, your application can be processed. Then, the CIHCP must determine if you are eligible within 14 days.

After turning in your application, you must report within 14 days any changes in your address, income, resources, people living with you, or application for or receipt of Medicaid, TANF, or SSI.

SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

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

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

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

SUS RESPONSABILIDADES

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

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

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

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

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

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

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

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

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

DICKENS COUNTY INDIGENT HEALTH

Dickens County Indigent Health
P.O. Box 179
Dickens, Texas 79229

If you own an automobile, you must provide the following information:

Make: _____

Model: _____

Year: _____

License Plate Number: _____

Owner's Name: _____

RIGHTS AND RESPONSIBILITIES

1. _____ I have been informed that the Dickens County Indigent Health Care Program does not discriminate. I can apply for services regardless of sex, race creed, national origin, religious beliefs, sexual orientation, or disability.

2. _____ As an Indigent Health Care recipient, if I need specialized care, my Primary Care Physician (PCP) will need to provide Dickens County Indigent Health Care with written referral to a specialist for medical treatment in order for the bill to be paid.

3. _____ I have been informed that Indigent Health Care covers only medically necessary services.

4. _____ I have been informed that Indigent Health Care covers only three prescriptions per month.

5. _____ I have been informed that Dickens County Indigent Health Care require that I ask my medical care providers for generic prescriptions if available.

6. _____ I have been informed that I am responsible for notifying my medical care providers of my eligibility and instructing those providers to submit eligible unpaid medical bills to Dickens County Indigent Health Care Office within 95 days from date of service.

7. _____ I have been informed that failure to notify my providers will result in non-payment of my medical bills.

8. _____ I have been informed that I must present my eligibility card or letter when I attend a medical appointment, go to the hospital, or present or pickup a prescription at the pharmacy.

9. _____ I have been informed that I must notify the office within fourteen (14) days of any changes in my situation, (such as changes in income, property, household members, address, vehicles, or applying for or receiving SSI, TANF, Medicaid, Lawsuit, Unemployment Benefits, Worker's Compensation Benefits, or any type of correspondence or approval of Social Security benefits).

10. _____ I have been informed that if I fail to report changes that make me ineligible, I will be held responsible for payment or reimbursement of any medical services rendered to me or paid on behalf that I received after becoming ineligible. I understand I may be subject to prosecution under the Texas Penal Code.

(Print Your Name) _____(Today's Date)_____

(Signature)_____

DICKENS COUNTY INDIGENT HEALTH

At the time of your appointment, you must bring ALL OF THE DOCUMENTATION BELOW THAT APPLIES TO YOU.

- Automobile registration
- Checking Account Statement
- Disability Insurance Award Letter or Check
- Earnings Statement from Employer
- Federal Income Tax Return
- Mail Addressed to you or another member of your household
- Notice of TANF, Food Stamp, or Medicaid Benefits
- Paycheck or paycheck stubs
- Savings Account Statement
- Self-Employment Bookkeeping, Sales and Expenditure Records
- Social Security Award Letter, Check or Denial Notice
- Social Security Numbers if available for all Household Members
- Texas Drivers License or Other Official Identification
- Unemployment Compensation Award Letter or Check
- Veterans Administration Award Letter or Check
- Voter's Registration Card
- Worker's Compensation Award Letter or Check
- Verification of Application for other Assistance Programs
- Other _____

Optional Health Care Services

TDSHS-established Optional Health Care Services

	Payment Method
• **Advanced Practice Nurse Services**	NP/CNS/
• **Ambulatory Surgical Center (Freestanding) Services**	ASC Fee Schedule
• **Colostomy Medical Supplies and Equipment**	DME Fee Schedule
• **Counseling Services**	Psychologist Fee Schedule
• **Dental Care**	Dentist-Orthodontist Fee Schedules
• **Diabetic Medical Supplies and Equipment**	DME Fee Schedule
• **Durable Medical Equipment**	DME Fee Schedule
• **Emergency Medical Services**	Ambulance Fee Schedule
• **Home and Community Health Care Services**	Rate Per Visit
• **Physician Assistant Services**	Physician Assistant Fee Schedule
• **Vision Care, including Eyeglasses**	Optometrist & Optician Fee Schedules
• **FQHC (Federally Qualified Health Center) Services**	Rate Per Visit
• **Occupational Therapy Services**	Occupational Therapist Fee Schedule
• **Physical Therapy Services**	Physical Therapist Fee Schedule
• **Other medically necessary services or supplies**	Fee Schedule or negotiable rate

Negotiate rates with providers for optional service procedure codes not listed in the Fee Schedules. For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Advanced Practice Nurse (APN) Services

An APN must be licensed as a registered nurse (RN) within the categories of practice, specifically, a nurse practitioner, a clinical nurse specialist, a certified nurse midwife (CNM), and a certified registered nurse anesthetist (CRNA), as determined by the Board of Nurse Examiners. APN services must be medically necessary and provided within the scope of practice of the APN.

The Medicaid rate for NPs and CNSs reflect 92% of the rate paid to a physician for the same service and 100 % of the rate paid to physicians for laboratory, X-ray, and injections.

Payment Standard for a Nurse Practitioner, a Clinical Nurse Specialist, and a CNM. Use the Fee Schedule for Texas Medicaid Nurse Practitioner and Clinical Nurse Specialist at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.

2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

(APN Payment Standard continued on next page)

BEHAVIORAL/ FRAUD GUIDELINES
DICKENS COUNTY INDIGENT HEALTH CARE

BEHAVIORAL.

- All applicants and qualified clients are required to comply with all State and County policies and guidelines in order to receive services through the Dickens County Indigent Health Care (IHC) Program.
- All applicants and qualified clients who are rude and display disruptive or abusive language and behavior will not be seen. Our personnel will be protected from dangerous situations. Physical and combative confrontations are grounds for immediate termination from the IHC Program.
- All qualified clients are expected to comply with the medical regime proposed by their Physician's or Specialist's Office. This includes keeping scheduled appointments. Clients will be terminated from the IHC Program for repeated non-compliance.
- No qualified client shall receive any medication without periodic Physician evaluation every three to six months.
- Qualified clients will be terminated from the IHC program for illicit drug usage and continued alcohol abuse, if not currently and actively participating in a supervised rehab program.

FRAUD/NON-COMPLIANCE.

- Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits.
    1. making a false and/or misleading statement,
    2. misrepresenting, concealing, or withholding facts,
    3. violating any provision of the CIHCP Act, the CIHCP regulations or State Statutes relating to the use, or acquisition of CIHCP.
- Non-compliance is the failure to report, whether deliberate or not, the following:
    1. initial income or change thereof;
    2. resources - currently owned, the selling, trading, or purchasing of,
    3. change of address,
    4. change in household members,
    5. change in marital status,
    6. application, approval, or denial of Social Security, SSI, or Medicaid
    7. eligibility for other medical coverage such as, but not limited to, private insurance, V.A., Worker's Compensation, Crime Victims Assistance,
    8. other items as used to determine eligibility,
    9. in addition, a client is determined to be in non-compliance if he/she fails to apply for a medical coverage program, such as those listed in #7, for which he/she has been determined to be potentially eligible.
- Consequences of Fraud/Non-Compliance:
    1. Length of suspension is determined by the number of months the infraction covered, in the case of multiple infractions each infraction will be considered separately,
    2. In the case of a second instance of non-compliance eligibility will be suspended for a period of 12 months,
    3. Should there be a third instance of non-compliance the applicant will be permanently disqualified.
    4. It is the responsibility of the client to notify the IHC office that he/she wishes to reapply for IHC at the end of the suspension period.
    5. Client shall be required to reimburse Dickens County for the cost of benefits they were ineligible to receive,
    6. Client shall be administratively ineligible for Dickens County IHC benefits in accordance with Dickens County IHC Policies and Procedures, and
    7. Client may be subject to prosecution under the Texas Penal Code.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES.

_____ _____

Applicant Signature Date

_____ _____

Spouse's Signature Date