COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Collin County Health Care Services 2019 Novel Coronavirus (COVID-19) Testing Application

UNINSURED COLLIN COUNTY RESIDENTS ONLY

Patient Information--**Applicant or Parent must provide Driver's License or Proof of County Residency**		
Last Name:	**First Name:**	
Physical/Street Address (P.O. Box is NOT accepted):	**City:**	**Zip:**
County (Only Collin County Residents are Eligible):	**Phone:**	**Date of Birth:**
If the patient is under 18 years, name of parent/guardian:	____________ **(Parent/Guardian First Name)**	____________ **(Parent/Guardian Last Name)**

Reason for COVID-19 Testing (please check all that apply)				
☐ **I have symptoms of COVID-19 (if yes, please check off all symptoms you have experienced)**				
☐ Abdominal Pain	☐ Diarrhea	☐ Headache	☐ Red Eyes	☐ Sore Throat
☐ Chills	☐ Fever Temp:__________	☐ Muscle aches	☐ Runny Nose	☐ Vomiting
☐ Cough	☐ Fever (Subjective)	☐ Nausea	☐ Shortness of Breath	☐ Other:
☐ **I have had contact with someone who has COVID-19**				
☐ **My work is requiring me to get tested**				
☐ **Other, please explain:**				

Self-Certification of Collin County Residency and Medically Uninsured Status

_______ (Patient Initials) I hereby certify, under penalty of perjury, my (or my child's) status as a medically uninsured resident of Collin County: I affirm that I (or my child) currently reside(s) in Collin County. I affirm that I am not (or my child is not) presently covered by any public or private health insurance program (i.e. Blue Cross, United Healthcare, Medicaid, Medicare, etc…).

I understand that Collin County Health Care Services has authorized my chosen health care provider to perform certain COVID-19 related services for me (or my child) free of charge based on the information I have provided on this form. By signing this form I agree that the statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I understand that giving false information could result in disqualification and repayment for Covid-19 services.

Consequence of Fraud Policy:
If, after due process, a person is found to have intentionally misrepresented information in order to receive COVID-19 services, that person:

- shall reimburse Collin County for the cost of benefits they were ineligible to receive;
- shall be administratively ineligible for Collin County COVID-19 services in accordance with County Policies/Procedures;
- shall be financially responsible for any insurance or other billing generated by their chosen health care provider as allowable for services received; and
- may be subject to prosecution under Texas Penal Code.

I understand that as part of the provisions of healthcare services, Collin County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

Print name of person who completed application	Signature of person who completed application	Relationship to Patient	Date

FOR OFFICE USE ONLY—Fax Completed Form to 972-547-4861		
Date Test Performed:	**Type of COVID-Test (FDA Approved or EUA Authorized Only):** ☐ **PCR (Oral)** ☐ **PCR (Nasal or Throat)** ☐ **Serology (IgG)**	**Billed Amount:**

DRAFT

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

	☐ Serology (IgM) ☐ Recommended Confirmatory Testing by PCR	

DRAFT