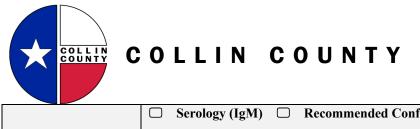


Collin County Health Care Services 2019 Novel Coronavirus (COVID-19) Testing Application UNINSURED COLLIN COUNTY RESIDENTS ONLY

Patient Information**Applicant	or Parent must pro	vide Driver's Li	cense or	Proof of Coun	ty Residency**					
Last Name:		First Name:								
Physical/Street Address (P.O. Box is NOT accepted):		City:			Zip:					
County (Only Collin County Resident are Eligible):	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 Te	mp:	Muscle aches	Runn	ny Nose	Over the second seco					
Cough Fever (Su	ubjective)_	Nausea 🗆	Short	tness 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 that person: shall reimburse Collin County for the shall be administratively ineligible for shall be financially responsible for any for services received; and may be subject to prosecution under T 	cost of benefits they we Collin County COVIE y insurance or other bill	ere ineligible to reco -19 services in acc	eive; ordance v	with County Polic	ies/Procedures;					
I understand that as part of the provision information describing, among other this treatment, and any plans for future care	ngs, my health and med									
Print name of person who completed application	Signature of perso completed applic		elationsl	hip to Patient	Date					
FOR OFFICE USE ONLY—Fax Completed Form to 972-547-4861										
	ID-Test (FDA Approv	ed or EUA Autho	rized Or		Billed Amount:					



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

	Serology (IgM)	Recommended Confirmatory Testing by PCR	