Sandoval County Healthcare Assistance Program Application Checklist

To determine your eligibility the Person Seeking Services (PSS) must meet the ninety (90) day residency requirement and the income eligibility. The PSS must not be eligible for Medicare, Medicaid or any third-party insurance. HCAP will cover Dental/Vision if you don't have coverage. To determine your eligibility, please answer the following questions.

1. Do you have any type of insurance coverage? Yes ☐ No ☐ If yes, please select the type of coverage:

- ☐ Medicare/Medicaid
- ☐ Medical Insurance (Commercial insurance)
- ☐ Dental Insurance/ Vision
- ☐ Life Insurance
- ☐ VA Coverage
- ☐ Pharmaceutical Coverage
- ☐ Burial Insurance

2. Have you been a resident of Sandoval County for the past 90 days? Yes ☐ No ☐

3. Does your income fall within the following Federal Poverty Level Guidelines? To determine your eligibility please check one of the following household income boxes.

- ☐ Household income for 1 person = up to $ 2,527
- ☐ Household income for 2 persons = up to $ 3,427
- ☐ Household income for 3 persons = up to $ 4,326
- ☐ Household income for 4 persons = up to $ 5,225
- ☐ Household income for 5 persons = up to $ 6,125
- ☐ Household income for 6 persons = up to $ 7,024
- ☐ Household income for 7 persons = up to $ 7,923
- ☐ Household income for 8 persons = up to $ 8,823

4. Are you a Veteran? Yes ☐ No ☐ If a Veteran, do you currently have a Medical Services Provider? Yes ☐ No ☐ If No, please indicate where you receive health care assistance _____.

If you have answered question one through four and can provide documentation to show proof of residency, income and proof of veteran status (if applicable), please fill out the attached application and submit the application and required documents to the Community Health Program Office.

If you are living with a relative or an advocate you are required to fill out the Verification Residency Letter.

If you have questions about the program please call (505) 867-2291 Ext. 1725

PSS Last Name: _____First Name: _____MI: _____