



Sandoval County Healthcare Assistance Program

VERIFICATION OF INCOME

Health Care Assistance Program Applicant Name: _____

(Applicant/Relative/ Friend or Advocate Address)

(City)

(State)

(Zip Code)

(Phone Number)

If Applicant is working for cash, indicate the amount:

(Amount)

(How often)

If Relative/Friend or Advocate is providing assistance, indicate the amount:

(Amount)

(How often)

If Relative, Friend or Advocate, please explain the financial arrangement you have with the applicant:

Print Name: _____
(Applicant)

Signature: _____
(Applicant)

Date: _____

Print Name: _____
(Relative/Friend or Advocate)

Signature: _____
(Relative/Friend or Advocate)

Date: _____

STATE OF NEW MEXICO)

) SS.

COUNTY OF SANDOVAL)

The foregoing was acknowledged before me this ____ day of _____,

By _____

Notary Public _____ **My Commission Expires** _____



Sandoval County Healthcare Assistance Program

VERIFICATION OF RESIDENCY LETTER

Health Care Assistance Program Applicant Name: _____

(Relative/Friend or Advocate Address)

(City) (State) (Zip Code) (Phone Number)

How long has applicant lived at this address?

From: _____
(Month/Year)

To: _____
(Month/Year)

To complete the HCAP application the relative, friend or advocate is required to provide verification of residency in Sandoval County, please provide (one) of the following documents:

Valid NM Driver's License/ID
Property Tax Bill

Rental/Lease Contract
Utility bills for the past 90 days prior to application

Please list all members living with the above named household:

_____	_____
_____	_____
_____	_____

Explain the arrangement you have with the applicant:

Print Name: _____
(Applicant)

Signature: _____
(Applicant)

Date: _____

Print Name: _____
(Relative/Friend or Advocate)

Signature: _____
(Relative/Friend or Advocate)

Date: _____

STATE OF NEW MEXICO)
COUNTY OF SANDOVAL) SS.

The foregoing was acknowledged before me this ____ day of _____,

By _____

Notary Public _____ My Commission Expires _____