Sandoval County Healthcare Assistance Program Application

Please fill out the application and attach the required documentation to the application. If you are living with a relative or an advocate, you are required to fill out the Verification Residency Letter.

Last Name | First Name | MI | Date of Birth | Age

Home Address (Number and Street) | Apt.# | Home Phone #

City | State | Zip Code | Work Phone | Cell Phone

Mailing Address or P.O. Box | Apt.# | City | State | Zip

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Below please mark one or more to indicate what this person considers himself/herself to be. (Optional)

☐ African American
☐ Hispanic American
☐ Native American
☐ Pacific American
☐ Caucasian (European)
☐ Asian American
☐ Multi-racial
☐ Other _____

List all members living in the home

Last Name	First Name	Date of Birth (mm/day/yr.)	Relation to Applicant	Gender (M or F)	Race (see list above)

Sandoval County Health Care Assistance Program

The Sandoval County Healthcare Assistance Program requires the Person Seeking Services (PSS) to verify residency and income.

1. To verify residency you are required to submit (**two**) of the following documents:

☐ Valid New Mexico Driver's License/or New Mexico photo type of identification
☐ Rental/lease contract
☐ Property tax bills
☐ Utility bills for the past 90 days prior to the date of application (**PSS's name and address must be on bill**) must be electric, gas or water
☐ If PSS is living with a relative or friend you are required to complete the VERIFICATION OF RESIDENCY LETTER.

2. To verify income PSS is required to submit (**one**) of the following documents:

☐ Income – employee pay stubs for the past 90 days verifying wages, Disability, Pensions, Retirement, Social Security, Veteran Benefits, Student Loans, Scholarships, Unemployment, grants or other financial support you are receiving.
☐ If PSS is self-employed – Copy of most current income tax return, including state/federal forms, W2's, Schedules C, Itemized profit and loss statement for the last three months and NM Gross Receipts Tax.
☐ If PSS works for cash, or is receiving assistance from a relative, advocate or friend they must fill out the Verification of Income Form.
☐ If PSS is unemployed, they must provide the Verification of Income from head of household where the PSS resides stating how the PSS's expenses are being sustained.
☐ If PSS receives child or spousal support, a court order letter document is required
☐ If PSS is homeless and/or living with a family member, or advocate, those individuals must fill out an HCAP Residency Verification Form and provide proof of residency in Sandoval County
☐ If PSS is deceased, a spouse, family member, or responsible party shall be the PSS and required to Provide the deceased proof of residency and income

3. To verify Veteran Status submit (**one**) of the following documents:

□ Certificate of Veteran Status issued by the VA
□ DD Form 214/215
□ NGB 22/22A

4. To determine eligibility please check (**one**) off the following household income box.

☐ 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

_____ _____
Signature of Person Seeking Services Date

_____ _____
Other Responsible Party Seeking Services Date

_____ _____
Provider or Health Care Assistance Staff Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Sandoval County to obtain the information necessary to process my request for reimbursement through the Sandoval County Healthcare Assistance Program. I authorize the Provider, to release information to the Sandoval County Healthcare Assistance Program concerning my diagnosis and treatment to include specifically: Medical Records, Social History, Treatment Plan, Consultations, Evaluations and Assessments.

Verified Statement of qualification for Sandoval County Healthcare Assistance Program: (Please select each box)

☐ I am the PSS or legally qualified guardian or advocate of the PSS who is completing this application and verified statement stating that I have no Medical, Dental, and Pharmaceutical insurance.

☐ I authorize the release of all medical records and/or financial records needed by the Sandoval County Healthcare Assistance Program that will be utilized in processing my claim.

☐ I authorize the contracted providers(s) and the Healthcare Assistance Coordinator to make any inquiry of any person, firm or corporation to provide pertinent financial and residential information as may be requested. I further agree to hold harmless any person, firm or corporation, including the financial institution or agency from any liability whatsoever for the release of information relevant to this statement and the investigation of the facts pertinent to this claim.

☐ I the PSS or person applying on behalf of the PSS, declares the above to be true and correct under penalty that any false statements made knowingly shall constitute a felony.

Notary Required

_____ _____
(Print Name) **Date**

_____
(Signature)

_____ _____
(Print Advocate Name) **Date**

_____
(Signature)

STATE OF NEW MEXICO)
)SS.
COUNTY OF SANDOVAL)

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

By _____

Notary Public _____ My Commission Expires _____