



**Healthcare Assistance Program**  
Roosevelt County Courthouse  
109 W. First St., Portales, NM 88130  
Telephone 575.356.5307 • Fax 575.356.8307

## **Application Instructions and Checklist of Documents**

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1. Before completing the application, read the Verified Statement and sign it. Your signature will bind you to the provisions of the verified statement.

2. **General list of documents** (see below) must be submitted with your application  
**Please answer all questions.** List all members living within the same household, whether dependent or not. Provide social security numbers and dates of birth. If the patient or other member(s) of the household is undocumented, please provide birth certificates, marriage license, immigration documents or other legal documents that will assist in identifying the household unit and their status any information that you are uncertain about can be verified during the review.

A notification will be given of any additional documents needed at the time of the submittance of your application. Failure to provide any of the necessary documents will result in the denial of your application. Any information that you provide to determine eligibility will be held confidential, except as allowed by law and regulation.

### **Provide the following documents:**

**Income-Income Limits:**

1. \$12,000 – single
2. \$16,000 – married + \$ 1200 (each additional dependent; up to four (4) total
3. \$20,800 maximum.

Current Income tax return includes state/ federal forms with all W'2's. If you did not file a tax return, contact local office for further instructions.

Current check stubs verifying wages. Income can be wages earned or unearned as follows: Social Security, Veterans, or retirement benefits, student loans, scholarships, grants or other financial support, JTPA, Disability, Unemployment or Worker's Compensation, Supplemental Security Income (SSI), Welfare (aka TANF)

**Residency-** 90 days prior to the treatment of the patient(s)  
Rental Lease contract; property taxes; voters registration; school, church, or public agency documents; two (2) Non-related references with name, mailing address and phone number

### **Assets - Resource Limits:**

Checking/savings account (bank statements); other investments such as stocks/bonds, CD's; escrow accounts; settlements; inheritance; divorce petitions and/or decrees.

### **Debts:**

Please provide your most recent utility bills such as electric, gas, water, rental receipts.

**\*\* Note: Items required by each County may vary \*\***

**Roosevelt County Health Care Assistance Application**

**1. Patient (List all members of the household at the time of application in Item 2)**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

Marital Status:  Married  Domestic Partnership  Divorced  Widowed  Single

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**For referral purposes only, indicate the information below:**

**Resident Alien Status :**

U.S. Citizen  Temporary  Permanent **Note\*\* Non-U.S. Citizens must provide proof of status.**

**Provider** Name \_\_\_\_\_ Date of Service \_\_\_\_\_

**Provider** Name \_\_\_\_\_ Date of Service \_\_\_\_\_

**2. Residency:**

List physical address \_\_\_\_\_

**Do you:**  Rent  Own  Shared rent with other members  Supplied free of charge  Homeless

List **prior** physical residence if less than (1) year at the current address

**Physical address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_

(2) Non-Related References

1. **Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_ **Zip** \_\_\_\_\_

2. **Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_ **Zip** \_\_\_\_\_



**6. Medical Coverage:**

Is there any medical coverage for the family?  Yes  No  N/A

Name of the Insurance \_\_\_\_\_  
*(Include copy of card)*

Does any other member of the household have medicaid/medicare?  Yes  No

Medical coverage for the **pregnancy** related services?  Yes  No

If so, name of program \_\_\_\_\_

Date of delivery \_\_\_\_\_ Has the patient been referred to apply for EMSA  Yes  No  N/A

**7. Public Assistance:**

Has the **patient** or anyone else within the household recently applied for the following?

SSI  Welfare (aka TANF)

Date Filed \_\_\_\_\_ Status \_\_\_\_\_

Person that applied \_\_\_\_\_

Explain if necessary \_\_\_\_\_

**8. Assets: (value)**

\*\* (Call your County HCAP Office to ask if necessary)

**(Provide ALL proof of any investments or other properties owned by the applicant/patient or household unit as follows)**

Personal Home \$ \_\_\_\_\_

Checking Accounts \$ \_\_\_\_\_

Saving \$ \_\_\_\_\_

Investments \$ \_\_\_\_\_

Escrow Account Equity \$ \_\_\_\_\_

Stocks or bonds \$ \_\_\_\_\_

Auto \_\_\_\_\_ \$ \_\_\_\_\_

If the patient is **deceased**, was there a life insurance?  Yes  No Full Value \$ \_\_\_\_\_  
*(Explain how excess proceeds were spent on comments of this application.)*

**8.A** Have you **sold** any property(s) in the past year?  Yes  No Income from Sale \$ \_\_\_\_\_

**9. Debts:**

Do you receive other monies from a friend or relative to compensate your monthly expenses?  Yes  No  
Amount \$ \_\_\_\_\_ (Provide proof)

**\*\* Note: Some County residents are not subjected to complete Section 9.**

**Verified Statement: Of Qualification for Roosevelt County Health Care**

- That I am the patient or the person having custody of the patient who has completed this application and verified statement.
- That there is no insurance to cover other than what was stated on this application.
- That I will authorize the release of all medical records and/or financial records needed by the Roosevelt County HCAP that will be utilized in processing my claim.
- That I will authorize the contracted provider(s) and the Health Care Administrator 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 save and hold harmless any person, firm or corporation, including any 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.
- That I do not have any unforeseen resources available for this service(s) however, if a lawsuit arises the resources will be applied to repay for the services to Roosevelt County HCAP.
- That I, the patient or person applying on behalf, declare the above to be true and correct under penalty that any false statements made knowingly shall constitute a felony.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Spouse/Partner

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

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

By: \_\_\_\_\_.

NOTARY PUBLIC \_\_\_\_\_ MY COMMISSION EXPIRES: \_\_\_\_\_

\_\_\_\_\_  
Name of party completing form (if other than patient)

Comments \_\_\_\_\_  
\_\_\_\_\_



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**Patient Referral  
Out of County Hospital**

Applicant Name \_\_\_\_\_

Address \_\_\_\_\_

Referred to \_\_\_\_\_ Date Referred \_\_\_\_\_

Transferred by Ambulance or Air:  Yes  No

Referring Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Please provide transfer consent form through Medical Records department.**

**Patient Information Release:**

I authorize release of the above information to the Roosevelt County HCAP Administrator as representative of the Roosevelt County HCAP Fund. Said information may also be released to any hospital and/or ambulance service associated with this application. Such release is to assist in processing my application to HCAP fund.

\_\_\_\_\_  
Signature Applicant or Responsible Party

\_\_\_\_\_  
Date



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**Residency**

Date \_\_\_\_\_

I, \_\_\_\_\_ of \_\_\_\_\_

do verify that \_\_\_\_\_

has resided in Roosevelt County at, \_\_\_\_\_

for 90 days preceding his/her stay at (Hospital/Ambulance) \_\_\_\_\_

Hospital Admission Date \_\_\_\_\_

Ambulance Transportation Service Date \_\_\_\_\_

Signed This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Signature of Verifying Person

**Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.**

\_\_\_\_\_  
**Notary Public**

**(SEAL)**

My Commission Expires:



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**Medical Assistance  
(Human Services Department)**

Applicant Name \_\_\_\_\_

S.S.N: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Responsible Party \_\_\_\_\_

Type of Benefit:

- Has Applied for assistance  
Medicaid No. \_\_\_\_\_
- Pending reason \_\_\_\_\_ Effective date \_\_\_\_\_
- Reason for Denial \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If no application has been submitted, please indicate if applicant is eligible.

I hereby authorize the New Mexico Department of Human Services Income Support Division to release the above information to the HCAP Fund Administrator for the Roosevelt County Hospital Claims Board and any hospital and/or ambulance service connected with this claim.

\_\_\_\_\_  
Applicant Signature or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Verifying Case Specialist

\_\_\_\_\_  
Date



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### Household Expenses

<b>Debt/Expense</b>	<b>Balance</b>	<b>Monthly</b>	<b>Debt/Expense</b>	<b>Balance</b>	<b>Monthly</b>
Rent/Mortgage			Dr.		
Gas, Water, Electric			Dr.		
Auto Insurance			Telephone		
Health Insurance			Cable		
Home Insurance			Day Care		
Vehicle			Child Support		
Loan			Pharmacy		
Other			Other		





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**Social Security Benefits**

Applicant Name \_\_\_\_\_ S.S.N \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

**Social Security Administration Please Complete the Following:**

Date Applied \_\_\_\_\_

Type of Benefit and Total Amount Paid:

SSI \_\_\_\_\_

Medicare \_\_\_\_\_

Date approved \_\_\_\_\_ Date denied \_\_\_\_\_

Reason denied \_\_\_\_\_

Case pending \_\_\_\_\_

**INFORMATION VERIFIED BY:**

\_\_\_\_\_  
Social Security Representative

\_\_\_\_\_  
Date



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### Rental Information

Date: \_\_\_\_\_

Applicant: \_\_\_\_\_

I hereby authorize my landlord, \_\_\_\_\_ to release the following information to the HCAP Administrator for the Roosevelt county HCAP hospital Claims Fund and any hospital or ambulance service connected with this claim.

Landlord to Complete

Address \_\_\_\_\_

Move In Date \_\_\_\_\_

Move Out Date \_\_\_\_\_

Any other information you might want to offer that you feel would be pertinent to this application for medical assistance:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Landlord or Relative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Telephone Number:

**\*\*\*\*\* Note To Applicant \*\*\*\*\***

If you have lived at several different places in the last four months, you must have a form filled out for each residence. If you are living with relatives, you must so state on the form and have the relative sign the form and supply a phone number.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date



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**Verification of Unemployment Benefits**

I hereby authorize the release of the requested information to the HCAP Administrator for the Roosevelt County HCAP Fund and hospital and/or ambulance service connected with this claim.

Name \_\_\_\_\_ SSN \_\_\_\_\_

The above named person has submitted and indigent claim to Roosevelt County. I am required to verify income sources to determine the Applicant's eligibility for HCAP funds, including any Unemployment Benefits that may have been applied for or received by the above named applicant. Please complete this form and return it to me at the above address at your earliest convenience. **Thank you for your cooperation!**

\_\_\_\_\_  
Applicant Date

\*\*\*\*\*

**To Be Completed By New Mexico Dept.Of Labor**

Effective Date of Eligibility \_\_\_\_\_

Benefits From \_\_\_\_\_ To \_\_\_\_\_

Amount \$ \_\_\_\_\_ weekly / biweekly / monthly

*If benefits were terminated, Date* \_\_\_\_\_

Total Earnings (Past Twelve Months) \$ \_\_\_\_\_

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Title Phone Number



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**Roosevelt County HCAP  
Notice of Privacy Practices Confirmation of Receipt**

This notice was provided by \_\_\_\_\_  
on \_\_\_\_\_.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_