Roosevelt County Health Care Assistance Application

1. Patient ***(List all members of the household at the time of application in Item 3)***

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**_____

3. List all members in the home:

Full Name	DOB	SSN	Relationship to Patient

Attach a separate sheet for additional members living within the home.

****Provide Proof of:**

4. Income: (Received In the past twelve [12] Months)

Employer_____ Gross Amt. Received $_____

Employer_____ Gross Amt. Received $_____

Unemployment $_____ Welfare (aka TANF) $_____ Food Stamps $_____
SSA/ SSI Benefits $_____ General Assistance $_____ VA$_____
Educational Assistance $_____ Workmen's Comp $_____ Pension $_____
Other Income not listed $_____

If you are employed this year, provide <u>current</u> check stubs verifying type of income earned for all employed.

Did the patient/ or head of household file a Federal / State Income Tax Return last year? ☐**Yes** ☐**No**
(Earned/ or Unearned Income) If you were exempt from filing provide proof.

5. Other Insurance or Liability:

Reason for medical treatment? ☐Personal injury ☐Motor vehicle accident (provide police report) ☐Work Related injury ☐Illness ☐Pregnancy ☐Other

Explain _____

_____

Are there any liability claims or legal action pending as a result of this hospitalization? ☐Yes ☐No
Explain _____

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_____

_____

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

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

Debt/Expense	Balance	Monthly	Debt/Expense	Balance	Monthly
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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Employment Verification

I hereby authorize my employer_____ to release the following information to the HCAP Administrator for the Roosevelt HCAP Hospital Claims Board, and hospital and/or ambulance provider connected with this claim.

Date Employed_____

Hourly Wage_____

Hours Worked Per Week_____

Gross Salary For Last 12 Months_____

Do You Offer Group Medical Insurance?	☐ Yes	☐ No
Is Employee Enrolled?	☐ Yes	☐ No
Do you Offer Group Life Insurance?	☐ Yes	☐ No
Is Employee Enrolled?	☐ Yes	☐ No

Any other information concerning this employee that you feel would be pertinent to the request for County assistance for medical expenses:

_____

_____

_____ _____
Employee Signature Date

The information above has been verified by_____ on _____.
Employer Date

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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