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

Social Security Number _____ U.S. Citizen Yes_____ No_____

Gender: (circle one) Male Female Marital Status: (circle one) Single Married Divorced Widowed

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

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

List all members living in the home

Full Name	Date of Birth (mm/day/yr.)	Social Security Number	Relation to Applicant	Gender (M or F)	Race (see list above)
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

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 photo type of identification
☐ Rental/lease contract
☐ Property tax bills
☐ A utility bill dated 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
☐ 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 a notarized letter 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 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 determine eligibility please check (one) off the following household income box.

☐ Household income for 1 person = up to $21,978
☐ Household income for 2 persons = up to $29,637
☐ Household income for 3 persons = up to $37,296
☐ Household income for 4 persons = up to $44,955
☐ Household income for 5 persons = up to $52,614
☐ Household income for 6 persons = up to $60,273
☐ Household income for 7 persons = up to $67,951
☐ Household income for 8 persons = up to $75,647

_____ _____
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 _____