Sandoval County Healthcare Assistance Program

Sandoval County Healthcare Assistance Program Application Checklist

To determine your eligibility the applicant must meet the ninety (90) day residency requirement and the income eligibility. The applicant must not be eligible for Medicare, Medicaid or any third party insurance. To determine your eligibility, please answer the following questions.

1. Do you have any type of insurance coverage? Yes ☐ No ☐ If yes, please select the type of coverage:

- ☐ Medicare
- ☐ Medicaid
- ☐ Medical Insurance (Any type of insurance)
- ☐ Dental Insurance
- ☐ Life Insurance
- ☐ VA Coverage
- ☐ Pharmaceutical Coverage
- ☐ Burial Insurance

2. Have you been a resident of Sandoval County for 90 days? Yes ☐ No ☐

3. Does your income fall within the following Federal Poverty Level Guidelines? To determine your eligibility please check one of the following household income boxes.

- ☐ Household income for 1 person = up to $21,589.50
- ☐ Household income for 2 persons = up to $29,100.50
- ☐ Household income for 3 persons = up to $36,611.50
- ☐ Household income for 4 persons = up to $44,122.50
- ☐ Household income for 5 persons = up to $51,633.50
- ☐ Household income for 6 persons = up to $59,144.50
- ☐ Household income for 7 persons = up to $66,655.50
- ☐ Household income for 8 persons = up to $74.166.50

4. Are you a Veteran? Yes ☐ No ☐ If you are a Veteran, do you currently have a Medical Services Provider? Yes ☐ No ☐ If No, please indicate where you receive health care assistance ____.

If you have answered question one through four and can provide documentation to show proof of residency and income, please fill out the attached application and submit the application and required documents to the Provider.

If you are living with a relative or an advocate you are required to fill out the Verification Residency Letter

Applicant's who are in need of Pharmacy Services only, are required to submit an application directly to the Sandoval County Health Care Assistance Program.

If you have questions about the program please call (505) 867-2291 Ext. 1704 or 1735

Patient Last Name: ________________________________ First Name: ______________________________ MI: ___________