Sandoval County Healthcare Assistance Program

VERIFICATION OF RESIDENCY LETTER

Health Care Assistance Program Applicant Name: _____

_____

(Relative/Friend or Advocate Address)

_____

(City) (State) (Zip Code) (Phone Number)

How long has applicant lived at this address?

From: _____ To: _____
(Month/Year) (Month/Year)

To complete the HCAP application the relative, friend or advocate is required to provide verification of residency in Sandoval County, please provide (one) of the following documents:

Valid Driver's License
Property Tax Bill
Rental/Lease Contract
Utility bill 90 day prior to application

Please list all members living with the above named household:

_____ _____

_____ _____

_____ _____

Explain the arrangement you have with the applicant:

_____

Print Name: _____
(Applicant)

Signature: _____ **Date :** _____
(Applicant)

Print Name: _____
(Relative/Friend or Advocate)

Signature: _____ **Date:** _____
(Relative/Friend or Advocate)

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

The foregoing was acknowledged before me this _____day of _____,

by _____

Notary Public _____My Commission Expires _____