



## Sandoval County Healthcare Assistance Program

### 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.**

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Last Name                                      First Name                                      MI                                      Date of Birth                                      Age

(   )

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Home Address (Number and Street)                                      Apt. #                                      Home Phone #

(   )

(   )

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City                                      State                                      Zip Code                                      Work Phone                                      Cell Phone

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Mailing Address or P.O. Box                                      Apt. #                                      City                                      State                                      Zip

Social Security Number \_\_\_\_\_ U.S. Citizen     Yes     No

Gender:     Male     Female                                      Marital Status:     Single     Married     Divorced     Widowed

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

- |  |   |
|--|---|
| <input type="checkbox"/> African Americans<br><input type="checkbox"/> Hispanic Americans<br><input type="checkbox"/> Native Americans<br><input type="checkbox"/> Pacific Americans | <input type="checkbox"/> Caucasian (European)<br><input type="checkbox"/> Asian Americans<br><input type="checkbox"/> Multi-racial<br><input type="checkbox"/> 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)



## Sandoval County Healthcare Assistance Program

**The Sandoval County Healthcare Assistance Program requires the applicant to verify residency and income.**

1. To verify residency you are required to submit (one) of the following documents:

- Current driver's license
- Apartment rental lease contract
- Property tax bills
- Voter's registration
- A current utility bill such as electric, gas or water
- If you are living with a relative or friend you are required to complete the VERIFICATION OF RESIDENCY LETTER.

2. To verify income you are required to submit (one) of the following documents:

- Check stubs for the past 60 days
- Most current Income tax return
- Disability, Pensions, Retirement, Social Security, Veteran Benefits, Workers' Compensation, Student Loans, Scholarships, Unemployment, grants or other financial support you are receiving.
- If self-employed – Most recent Income tax return includes state/federal forms with W'2's, Schedules C, C-EZ Schedule K or F, a signed itemized profit and loss statement for the last 3 months and NM Gross Receipts.
- If applicant is unemployed - provide a notarized letter stating how applicant's expenses are being sustained.

3. To determine eligibility please check (one) off the following household income box.

- |   |   |
|---|---|
| <input type="checkbox"/> Household income for 1 person = up to \$20,035.50  | <input type="checkbox"/> Household income for 5 persons = up to \$47,711.50 |
| <input type="checkbox"/> Household income for 2 persons = up to \$26,954.50 | <input type="checkbox"/> Household income for 6 persons = up to \$54,630.50 |
| <input type="checkbox"/> Household income for 3 persons = up to \$33,873.50 | <input type="checkbox"/> Household income for 7 persons = up to \$61,549.50 |
| <input type="checkbox"/> Household income for 4 persons = up to \$40,792.50 | <input type="checkbox"/> Household income for 8 persons = up to \$68,468.50 |

\_\_\_\_\_  
Signature of Responsible Party in Household

\_\_\_\_\_  
Date

\_\_\_\_\_  
Other Responsible Party in Household

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider/Health Care Assistance Staff

\_\_\_\_\_  
Date



## Sandoval County Healthcare Assistance Program

### 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/Assessments.

**Verified Statement of qualification for Sandoval County Healthcare Assistance Program:**  
(Please select each box that applies)

- I am the patient or legally qualified guardian or advocate of the patient 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 provider(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 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.
- I the applicant or person applying on behalf, declares the above to be true and correct under penalty that any false statements made knowingly shall constitute a felony.

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(Print Name)

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(Date)

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(Signature)

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(Print Advocate Name)

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(Date)

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(Signature)

STATE OF NEW MEXICO)

) SS.

COUNTY OF SANDOVAL)

The foregoing instrument was acknowledged before me this \_\_\_ day of \_\_\_\_\_, 2010

by \_\_\_\_\_

Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_.