



## 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 including Workman's Compensation. 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Medicare                             | <input type="checkbox"/> Life Insurance          |
| <input type="checkbox"/> Medicaid                             | <input type="checkbox"/> VA Coverage             |
| <input type="checkbox"/> Medical Insurance, BCBS, Cigna, etc. | <input type="checkbox"/> Pharmaceutical Coverage |
| <input type="checkbox"/> Dental Insurance                     | <input type="checkbox"/> 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.

- |   |   |
|---|---|
| <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 |

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

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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 not utilizing Outpatient Primary Care or Outpatient Behavioral Health and are in need of Pharmacy Services, 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.

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_