INDIGENT HEALTH CARE PROGRAM

100 S. Oliver Drive Aztec, NM 87401 (505) 334-4288

Print Form

APPLICATION FOR ASSISTANCE

1. Patient/Client Information *(Please print in INK or TYPE)*

Client ID #:

Last Name: _____ First Name: _____ MI: _____ Gender: ☐ F ☐ M

SSN: _____ DOB: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Mailing: _____ City: _____ State: _____ Zip: _____

Physical: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Message Phone: _____

2. Residency

Have you lived in San Juan County for at least ninety (90) days prior to treatment dates? ☐ Yes ☐ No

Proof of residency must be submitted for each date of service.

US Citizen: ☐ Yes ☐ No *IF you are not a US Citizen, are you a legal permanent resident?* ☐ Yes ☐ No

If you are not a US Citizen or legal permanent resident, then please provide INS documents verifying status.

3. Household

List yourself and all household members related and/or non-related.

Full Name	DOB Required	SSN	Relationship	Legal Dependent Yes/No	Employer/Business Name *(include if self-employed)*
			self		

Total number of person(s) in household: _____ *Please attach a separate sheet to report additional household members.*

4. Other Insurance and Liability

Medical Coverage: *Medicare, Medicaid, Indian Health Service (IHS or Contract Health), Private Insurance, Public Insurance or Medical program or assistance, Worker's Compensation, or any other medical resource.*

Does patient/client have medical coverage? ☐ Yes ☐ No

IF Yes, please specify: _____ *Policy Number:* _____

Was health care/treatment a result of an accident? ☐ Yes ☐ No

IF Yes, where did accident occur? ☐ Home ☐ Work ☐ Auto *Please explain fully on a separate sheet.*

Are any liability claims or legal actions pending as a result of the accident? ☐ Yes ☐ No

IF Yes, Explain fully: _____

5. Public Assistance/Asset/Income

A. Public Assistance

Does the household receive any of the following types of Public Assistance in San Juan County? ☐ Yes ☐ No

☐ TANF $ _____ ☐ Food Stamps $ _____ ☐ Public Housing $ _____ ☐ Tribal FA $ _____ ☐ Other $ _____

IF Yes, proof of Public Assistance must be submitted with this application.

Has the Patient/Client applied for medical assistance (Medicaid) through the NM Human Services Department? ☐ Yes ☐ No

IF Yes, Did you receive Approval/Denial letter? ☐ Yes ☐ No

B. Assets

Proof of Assets must be submitted with this application for all household members

Type/Source	Description	Yes/No	Owner of Asset	Value
Cash on Hand				
Checking Account				
Saving Account				
Investments/Stocks/Bonds				
Certificates of Deposit				
Other				

Please attach a separate sheet to report additional sources of assets.

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C. Income

Did the Patient/Client or household member responsible for Patient/Client file a Federal and/or State income tax return last year? ☐ Yes ☐ No

IF Yes, a copy of your tax return(s) must be submitted with this application including verification of untaxed income such as Social Security.
IF No, Please explain why an income tax return was not filed and skip to Section D.

Has there been any significant changes since your last year's tax return? ☐ Yes ☐ No

D. Income *(If you did not file a tax return last year please complete the following section:)*

Proof of income must be submitted with this application.

Source	Yes/No	Household Member Receiving Income	Year-to-Date Amount
Wages, Salaries, Tips			
Interest Income			
Alimony			
Business Income			
Capitol Gain			
IRA Distributions			
Pensions and Annuities			
Rental income			
Royalties/Partnerships/Trust			
Unemployment Compensation			
Social Security			
Other			

Please attach a separate sheet to report additional sources of income. Are there any adjustments to your gross income (in Section D) which should be considered? *IF Yes, Please explain on a separate attached sheet.*

State of New Mexico)
) SS
County of San Juan)

I, _____, having been duly sworn upon oath, depose and state as follows:

I understand that all information given by me in this application is subject to investigation and I authorize the San Juan County Indigent Hospital and County Health Care Board, or its agents, to make any inquiry of any person, firm, association, or corporation to furnish any information relating to this application an/or verification statement without liability whatsoever.

I have read this application in its entirety and know and understand the contents therein. Under penalties of perjury, I declare to the undersigned entity that the information stated in the application is true and correct to the best of my knowledge.

Signed this _____ Day of _____

_____
Signature of Patient/Client or Applicant

Subscribed and sworn to before me by _____

Signed this _____ Day of _____

My Commission expires: _____

_____
Notary Public