



**5. Other Insurance or Liability/ Seguro de responsabilidad**

Reason for medical treatment? *¿Porque razón fue el tratamiento?* (CHECK ONE ) (PONGA MARCA )  
Personal injury/Daño personal \_\_\_\_\_ Motor vehicle accident/ Accidente de automóvil (provide police report/ consigne el reporte de policía) \_\_\_\_\_ Work Related injury/ Daño en el trabajo \_\_\_\_\_ Illness/Enfermedad \_\_\_\_\_  
Pregnancy/Embarazo \_\_\_\_\_ OTHER/Otra razón \_\_\_\_\_ Explain/ Explique: \_\_\_\_\_

Are there any liability claims or legal action pending as a result of this hospitalization? *¿ Hay reclamos legales debido ha este servicio medico?* Yes/ Si \_\_\_ No \_\_\_  
Explain/ Explique: \_\_\_\_\_

**6. Medical Coverage/ Cubertura medical**

Is there any medical coverage for the family? *¿Hay cubrición medica para la familia?* Yes/Si \_\_\_\_\_ No \_\_\_\_\_  
For the patient? *¿ Para el paciente?* Yes/Si \_\_\_\_\_ No \_\_\_\_\_ N/A(No aplica) \_\_\_\_\_

Name of the Insurance? (include copy of card) *¿ Nombre de la clase de seguro? (Incluya una copia de su tarjeta)*

Does the patient or any other member of the household have medicaid/medicare? *¿Hay cubricion medica para el paciente o otro miembro del hogar de medicaid/medicare?* Yes/Si \_\_\_\_\_ No \_\_\_\_\_

Medical coverage for the pregnancy related services? *¿Cubrición medica pa ra el embarazo?* Yes/Si \_\_\_\_\_ No \_\_\_\_\_  
If so, name of program/ *Si tienie cubiertura ponga el programa:* \_\_\_\_\_  
Date of delivery/ *Fecha de su parto:* \_\_\_\_\_ Has the patient been referred to apply for EMSA? *¿El paciente ha aplicado para el servicio médico de emergencia?* Yes/Si \_\_\_\_\_ No \_\_\_\_\_ N/A (No aplica) \_\_\_\_\_

**7. Public Assistance/Otro tipo de asistencia publica**

(CHECK ONE ) (PONGA MARCA )

Has the patient or anyone else within the household recently applied for the following? *¿El paciente o otro miembro del hogar han aplicado para lo siguiente?* SSI/SSA(Disability/ Encapacitado) \_\_\_\_\_ Welfare(aka TANF) \_\_\_\_\_  
Date Filed/ *Fecha de registro:* \_\_\_\_\_ Status/ *Situación:* \_\_\_\_\_  
Person that applied/ *Persona que aplico:* \_\_\_\_\_  
Explain if necessary/ *Explique la situación:* \_\_\_\_\_

**8. Assets/Recursos o bienes** (GIVE VALUE) (PONGA EL VALOR)

**\*\* (Call your County IHC Office to see if necessary/ llame la oficina en su condado para saber si esto es necesario)**

**(Provide ALL proof of any investments or other properties owned by the applicant/patient or household unit as follows/ Prueba de TODOS inversiones o propiedades propio para el aplicante/paciente o el establecimiento doméstico:)**

Personal Home/ *Casa propia (valor de su propiedad)* \$ \_\_\_\_\_ Escrow Account/ *Cuenta en custodia de tercera persona* \$ (Equity/ *Equidad*) \$ \_\_\_\_\_ Stocks or bonds/ *Otros inversiones* \$ \_\_\_\_\_ Checking Accounts/ *Cuenta de cheque* \$ \_\_\_\_\_ Savings Account/ *Cuenta de ahorro* \$ \_\_\_\_\_ Investments/ *Inversiones* \$ \_\_\_\_\_

If the patient is **deceased**, was there a life insurance? *¿Si el paciente expiro usted recibio compensación de seguro?* Yes/Si \_\_\_ No \_\_\_ Full Value/ *Valor Completo* \$ \_\_\_\_\_ (Explain how excess proceeds were spent on comments of this application/ Explique como uso los ganancias de exceso en el comentarios de esta aplicación)

**8A.** Have you **sold** any property(s) in the past year? *¿Usted ha vendido propiedad en el ultimo año?* Yes/Si \_\_\_ No \_\_\_  
Income from Sale/ *Ingresos de venta* \$ \_\_\_\_\_

**9. Debts/Deudas**

Do you receive other monies from a friend or relative to compensate your monthly expenses? *¿Usted recibe otra ayuda monetario de un amigo o familiar para compensar sus deudas que paga mensual?* *¿* Yes/Si \_\_\_\_\_ No \_\_\_\_\_  
Amount/ *Cantidad* \$ \_\_\_\_\_ (Provide proof/ *Traiga prueba*)

**\*\* Note: Some County residents are not subjected to complete Section # 9. / Nota: Algunos residentes de diferente**



**INCOME SOURCE VERIFICATION**

Income Base Period From:

To:

**EMPLOYMENT- OCCUPATIONAL HISTORY**

|    |               |              |     |           |
|----|---------------|--------------|-----|-----------|
| 1. | Employee:     | Verified By: |     | Employer: |
|    | Gross Income: | From:        | To: | Address:  |
| 2. | Employee:     | Verified By: |     | Employer: |
|    | Gross Income: | From:        | To: | Address:  |
| 3. | Employee:     | Verified By: |     | Employer: |
|    | Gross Income: | From:        | To: | Address:  |

**OTHER SOURCES OF UNEARNED INCOME**

| INCOME SOURCE                             | AMOUNT | PERIOD | VERIFIED BY | DATE |
|---|--------|--------|-------------|------|
| Social Security<br>Received By:           |        |        |             |      |
| Social Security<br>Received By:           |        |        |             |      |
| Social Security<br>Received By:           |        |        |             |      |
| Social Security<br>Received By:           |        |        |             |      |
| Retirement Benefits<br>Received By:       |        |        |             |      |
| Veteran's Administration<br>Received By:  |        |        |             |      |
| Worker's Compensation<br>Received By:     |        |        |             |      |
| Unemployment Compensation<br>Received By: |        |        |             |      |
| Child Support or Alimony<br>Received By:  |        |        |             |      |
| General Assistance<br>Received By:        |        |        |             |      |
| Food Stamps<br>Received By:               |        |        |             |      |
| Rent<br>Received By:                      |        |        |             |      |
| Annuities<br>Received By:                 |        |        |             |      |
| Other<br>Received By:                     |        |        |             |      |
| In-Kind Statement:<br>Received By:        |        |        |             |      |

**Application and Verified Statement**

STATE OF NEW MEXICO )  
 ) ss Person who help to complete this application  
COUNTY OF CURRY: ) Signature: \_\_\_\_\_

VERIFIED STATEMENT OF QUALIFICATION FOR INDIGENT HOSPITAL CARE

I, \_\_\_\_\_, having been first duly sworn, depose and state:

1. That I am the patient or the person having custody of the patient who has completed the five page application and verified statement.
2. That I have read the five page application and verified statement and know and understand the contents of it.
3. That the information that I have given in the five page application and verified statement is true and correct.
4. That I, or the patient for whom I have legal responsibility, qualify as an indigent patient under the provisions of the Indigent Hospital Claims Act (Sections 27-5-1 to 27-5-18, NMSA 1978).
5. That I am without sufficient funds or source of income to pay the hospital bill of/from the \_\_\_\_\_ hospital in the amount of \$ \_\_\_\_\_ or any part of it.
6. That I do not have insurance to cover any part of the above amount owed to the hospital other than cited previously in this completed form.
7. That I have listed all of my assets on the five page application; and that I do not have any property or sufficient assets which can be subjected to or assigned for payment of the hospital bill.
8. That I do not foresee any possibility of being able to pay the hospital at any time in the future. If unforeseen resources should become available, these resources will be applied to repay the Curry County Indigent Hospital Fund part or all of the fund money paid under this request.
9. That I do not have a claim or any other legal action, other than those cited previously in the completed application, pending against any part in regards to this case.
10. That I authorize release by \_\_\_\_\_ hospital of any information concerning the final diagnosis and surgical procedure during the above hospitalization period of the Curry County Indigent Hospital Claims Board and that I understand such information will be used by the Board to perform utilization review and Claims processing functions. In addition, I am authorizing to release confidential medical, information, and/or HIV test (AIDs test) results contained in my medical records to Curry County Indigent Office. The information to be released is to be used for the purpose of: Indigent Claim Audit. I specifically request that the following type of information be released: all medical records to include history, physical, discharge summary, and/or operative reports (s) (if patient had surgery). I release Curry County Indigent Hospital Claim Office from liability and claims of any nature pertaining to disclosure of requested information contained in my medical record. The authorization is subject to revocation at any time, except to the extent that action had been taken in reliance on this consent prior to revocation. In any event, this authorization expires ninety (90) days from date of signature.
11. That I declare that the above is true and correct under penalty that any false statements made knowingly shall constitute a felony.

SIGNED this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
Signature of patient or person legally responsible for his/her care

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20

NOTARY PUBLIC \_\_\_\_\_

My commission expires: \_\_\_\_\_ 20

**Curry County**  
**New Mexico**  
**Board of County Commissioners**  
417 Gidding Street, Suite 100  
Clovis, NM 88101  
Phone (575) 763-6016 · FAX (575) 763-3656



**COMMISSIONERS**  
Fidel Madrid · District 1  
Brad Bender · District 2  
Dusty Leatherwood · District 3  
Seth Martin · District 4  
Kyle Cain · District 5

**County Manager · Lance A. Pyle**

## **TAX WAIVER**

This statement certifies that I am not required to file a Federal or State Tax Return for the year of \_\_\_\_\_ . I understand that I am knowingly providing this information and declare that this information is true and correct under penalty that any false statements made knowingly shall constitute felony.

\_\_\_\_\_  
Patient or Claimant Signature

\_\_\_\_\_  
Spouse if Joint Return

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires \_\_\_\_\_ 20\_\_\_\_\_.

(Seal)

If patient is a minor child, signature must be from a parent, guardian, or custodial representative.

**Curry County**  
**New Mexico**  
**Board of County Commissioners**  
417 Gidding Street, Suite 100  
Clovis, NM 88101  
Phone (575) 763-6016 · FAX (575) 763-3656



**COMMISSIONERS**  
**Fidel Madrid · District 1**  
**Brad Bender · District 2**  
**Dusty Leatherwood · District 3**  
**Seth Martin · District 4**  
**Kyle Cain · District 5**  
  
**County Manager · Lance A. Pyle**

## PROOF OF RESIDENCY

The Indigent Hospital Claims Administration requests verification of residency for \_\_\_\_\_ . Please provide the following information:  
Applicant's/Patient's Name

I verify that I have known this individual for the past \_\_\_\_\_ months/years I  
(circle one)  
declare that I am not related to this individual and state that this person resides

at: \_\_\_\_\_ located in  
Street Address  
\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
City/State mo/yr mo/yr

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_  
City/State/Zip

Tel. No: \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

**PLEASE RETURN TO:**

Curry County Indigent Hospital Claims Fund  
417 Gidding, Suite 100  
Clovis, NM 88101