Curry County Indigent Health Care Application

1. Patient/*Paciente* (List all members of the household at the time of application in Item 2/*Liste todos miembros en el articulo 2*)

LAST NAME/*APPELLIDO* FIRST NAME/*NOMBRE* MIDDLE/*SEGUNDO NOMBRE*

____

DOB/*Fecha de Nacimiento*____________________ Maritial Status/*Estado Civil*: M D W S

MAILING ADDRESS/*Dirección de Correspondencia*:____

City/*Ciudad*____________________State/*Estado*___________Zip Code/*Código Postal*___________ Telephone/*teléfono* _______________

For referral purposes only, indicate the information below/ *Por el proposito de referencia unicamente, indique la información siguiente.*

(CHECK ONE **X**) (*PONGA MARCA* **X**)

2. Residency/Residencia

List physical address/ *Liste su residencia fisica*: ____

Do you/ *Que Usted*: Rent/ *Renta* _____ Own/ *Dueño* _____ Shared rent with other members/ *Comparte con otros miembros del hogar* ______ Supplied free of charge/ *Mantanimiento gratis* _____ Homeless/ *Sin hogar* _____

List **prior** physical residence if less than (1) year at the current address/ *Liste su residencia fisica si menos que (1) año en la residencia ultima*: ____

PHYSICAL ADDRESS /*RESIDENCIA FISICA* **CITY /*CIUDAD*** **STATE/*ESTADO***

(2) Non-Related References / (*2) Referencias-No Relación*

1. ____

2. ____

NAME/ *NOMBRE* **MAILING ADDRESS/ *DIRECCION DE CORREO*** ***ZIP CODE/CODIGAL POSTAL*** **TELEPHONE/ *TELEFONO***

3. List all members in the home/ *Liste todos los miembros del hogar*

Full Name/*Nombre Completo* **DOB/***Fecha de nacim.* **Relationship to Patient**

____

____

____

____

____

____

Attach a separate sheet for additional members living within the home/*Junta otra pagina para listar todos miembros del hogar*

**Provide Proof/ *Traiga comprobacion de lo Siguiente:*

4. Income/*Ingreso* (**RECEIVED IN THE PAST 12 MONTHS/ *RECIBIDO EN EL ULTIMO AÑO*)

(**INDICATE** AMOUNT RECEIVED) (***INDICAR*** *CANTIDAD RECIBIDO*)

Employer: ____ Gross Amt. Received $__________

Empleador: ____ Cantidad Recibida $___________

Employer: ____ Gross Amt. Received $__________

Empleador: ____ Cantidad Recibida $ ___________

Unemployment/ *Desempleo $*__________ Welfare(aka TANF) *$* ___________Food Stamps/ *Estampillas de comida $*_________SSA/ SSI Benefits/ *Beneficios de Seguro Social/ Suplementario $* _________VA/ *Beneficios Veteranos $*_________Pension/*Retiro $*__________Educational Assistance/ *Ayuda de Educación $*__________ Workmen's Comp./*Compensación de Trabajo$* _________ General Assistance/ Asistencia General $__________ Other Income not listed/ *Otro ingreso no puesto*: *$*_________

If you are employed this year provide current check stubs verifying type of of income earned for all employed. *Si usted estuvo empleado en este ano traiga talones de cheque corriente para poder comprobar el tipo de ingreso que entra a la casa para el empleado(s).*

Did the patient/ or head of household file a Federal / State Income Tax Return last year? *¿Usted completo formas de immpuestos sobre los ingresos al gobierno Federal y del Estado?* Yes/ *Si* ____ No ____ (Earned/ or Unearned Income/ *Ingresos Percibidos*)

**** If you were exempt from filing provide proof. / *Si usted esta exonerado traiga preuba.***

5. <u>Other Insurance or Liability/ *Seguro de responsabilidad*</u>

Reason for medical treatment? ***¿Porque razón fue el tratamiento?*** (CHECK ONE **X**) (*PONGA MARCA* **X**)
Personal injury/*Daño personal* _____ Motor vehicle accident/ *Accidente de automóvil* (provide police report/ *consige 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. <u>Medical Coverage/ *Cubertura medical*</u>

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. <u>Public Assistance*/Otro tipo de asistencia publica*</u>

(CHECK ONE **X**) (*PONGA MARCA* **X**)
Has the **<u>patient</u>** 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/ *Encapacitad*o) ____ Welfare(aka TANF) ____
Date Filed/ Fecha *de registro*: ________________________ Status/ *Situación:* ________________________________
Person that applied/ *Persona que aplico:*____
Explain if necessary/ *Explique la situación:*____

8. <u>Assets*/Recursos o bienes*</u> (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 aplicacíon)

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. <u>Debts/Deudas</u>

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***

condados no necesitan completir sesción #9

***

Verified Statement of qualification for Curry County Indigent Health Care/*Verificación de Elegibilidad para recibir asistencia por El Cuidado de La Salud del Condado de Curry.*

< That I am the patient or the person having custody of the patient who has completed this application and verified statement/ ***Yo soy el paciente o la persona en custodia del paciente verificando la declaración de esta aplicación.***

< That there is no insurance to cover other than what was stated on this application/ ***Que no existe ningún tipo de seguro menos lo que fue indicado en esta aplicación.***

< That I will authorize the release of all medical records and/or financial records needed by the Curry County Indigent Health Care that will be utilized in processing my claim/ ***Que autorizo la relevación de toda información médico/ financiero para la evaluación de este reclamo por El Cuidado de La Salud del Condado de Curry.***

< That I will authorize the contracted provider(s) and the Indigent Health Care Administrator 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 save and 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/ ***Que autorizo que los proveedores médicos y el Administrador de la oficina del Cuidado de Salud pregunte a cualquier persona, firma, corporación o institución financiera o agencia para proveer información pertinente a financiero o residencial como sea solicitado. Ademas, yo consiento en dejar libre de responsablidad a cualquier persona, firma, corporación o institución financiera por dar la información relacionada a esta declaración y de la investigación de la verdad pertinente a este reclamo.***

< That I do not have any unforeseen resources available for this service(s), however, if a lawsuit arises the resources will be applied to repay for this service(s) to the Curry County Indigent Health Care ***/Que yo no tengo inesperado recursos disponibles para este servicio(s) y de cualquier modo si el procedimiento consiste de un pleito se reembolsarán los fondos a la Oficina de El Cuidado de La Salud del Condado de Curry, parcial o totalmente para el servicio(s) médico.***

< That I, the patient or person applying on behalf declare the above to be true and correct under penalty that any false statements made knowingly shall constitute a felony/ ***Que yo, el paciente o la persona en custodia declaro que toda la información es cierta y de cualquier información falsa provista deliberadamente constituye un delito.***

Signature/*Firma:* ____ **Date/*Fecha:*** ________________

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

The foregoing instrument was acknowledged before me this ____________ day of_____________________, 20____

by ____.

NOTARY PUBLIC_____________________________________ **MY COMMISSION EXPIRES:** ______________

____
Name of party completing form (if other than patient)
Nombre del individuo que completo la aplicación (si no es el paciente).

Comments/*Comentario*:____

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 Received By:				
Social Security Received By:				
Social Security Received By:				
Social Security Received By:				
Retirement Benefits Received By:				
Veteran's Administration Received By:				
Worker's Compensation Received By:				
Unemployment Compensation Received By:				
Child Support or Alimony Received By:				
General Assistance Received By:				
Food Stamps Received By:				
Rent Received By:				
Annuities Received By:				
Other Received By:				
In-Kind Statement: Received By:				

Application and Verified Statement

STATE OF NEW MEXICO)
) ss
COUNTY OF CURRY:)

Person who help to complete this application

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