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*_____ SSN/*No. Seguro Social*_____ 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*)

Resident Alien Status :

U.S. Citizen/ *Ciudadano de los Estados Unidos* _____ Temporary / *Residencia Temporal* _____ Permanent/ *Residencia Permanente* _____ ***(La Mica)*** Note/*nota*: ** If none of the above applies to you provide INS documents verifying status /*si ninguno se aplica ha usted, consige los documentos de la Inmigración que esta en proceso.*

Provider Name/***Proveedor** Medico*:_____ Date of Service/*Fecha de Servicio*:_____

Provider Name/***Proveedor** Medico*:_____ Date of Service/*Fecha de Servicio*:_____

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.*** **SSN/*Seguro Social*** **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. Other Insurance or Liability/ *Seguro de responsabilidad*

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. 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 para 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 X) *(PONGA MARCA X)*
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 aplicacíon)

8.A 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 condados no necesitan completir secsión #9***

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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.*
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< 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 disponsibles 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*: _____

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 six page application and verified statement.

2. That I have read the six page application and verified statement and know and understand the contents of it.

3. That the information that I have given in the six 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 six 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