STATE OF NEW MEXICO - MCKINLEY COUNTY
COUNTY HEALTH CARE HOSPITAL CLAIMS PROGRAM

Application and Declaration Statement

Application Date: ______________________ Hospital: ______________________

1. APPLICANT ______________________ Birthdate ______________ SS# ______________
   Address ______________________ Telephone No. ______________ Work Telephone No______________
   ______________________ Number of Dependent in Household? ______________

2. PATIENT ______________________ McKinley County Resident? y N How Long? __________

3. OTHER MEDICAL ASSISTANCE

   Is patient eligible for Medicare? Y N or Medicaid? Y N Does patient have Insurance? Y N

4. LIST ALL MEMBER OF HOUSEHOLD OF APPLICANT (including self)

Name	DOB	Relationship to Patient	SSN	Employer

5. INCOME INFORMATION FOR HOUSEHOLD (Le. Social Security, Welfare Assistance, Military or VA, Unemployment Compensation, Workman's Compensation, Retirement Benefits, Child Support, Alimony, Rental Income and Self Employment)

Source	Amount	Payment Schedule	Continuous?		If no, dates of payment will continue
		Wkly BI-Wk1y BI-Mthly Mthly	Y	N	
		Wkly. BI-Wkly BI-Mthly Mthly	Y	N	
		VAdy BI-VMy BI-Mthly Mthly	Y	N	
		Wkly Bl-Wkly BI-Mthly Mthly	Y	N	
		Wkly BI-Wkly BI-Mthly Mthly	Y	N	
		Wkly Bl-Wkly BI-MtWy Mthly	Y	N	
		Wkly BI-Wkly BI-Mthly Mthly	Y	N	

6. LIQUID ASSETS

   Cash on Hand $__________ Checking S__________ Savings S__________ Stocks & Bonds S__________

7. Have you ever applied for County Health Can assistance? Y N If yes, When?______________ Were you approved? Y N

All claims filed on your behalf are subject to eligibility of claim.

Eligibility Document Checklist

(Attached to application for future use)

- ☐ Proof of All income for the Household: Proof can be check stubs, bank statements, copy of your check, statement or letter from employer verifying your income.
- ☐ Proof of Unemployment: Proof can be copy of your unemployment check or registration with one or more employment agencies or statements from your pastor or other persons who know you and your employment status.
- ☐ Proof of Debts: Proof can be payment books, statements, letters or receipts including rent or house payments.
- ☐ Proof of Residence: Proof can be rent receipts for three months prior to hospitalization, a contract that was signed three months prior to hospitalization, or a statement from two people who can verify your length of residence in this county.
- ☐ Insurance: Bring all Insurance policies, receipts, and membership cards.
- ☐ Utility Bills: Bring most recent utility bills (electricity, gas, water, etc.).
- ☐ Financial Records: Bring account numbers and last financial statement of your checking and/or savings accounts.
- ☐ Income Tax Return: Bring a true copy of the most recent Federal IRS Form 1040 for the patient or person(s) legally responsible for the patient, and/or a true copy of the most recent New Mexico Income Tax Return.
- ☐ Other: Bring verification of all other assistance (Food Stamps, Energy Assistance' etc.

No patient will be considered unless the above requested information is on file. Application must be filed within 90 days following date of service.

CERTIFICATION

I certify that I am the patient or person applying for the patient who has completed and read this application and know and understand the contents of it, and swear that the information contained in it is true and complete to the best of my knowledge.

I understand that all information on this application is subject to investigation and I authorize the McKinley County Health Care Claims Board to make any inquiry of any person, firm or agency relevant to this application, and further authorize any person, firm or agency to provide pertinent information as may be requested by said Board.

I certify that I am unable to pay for the cost of this clinics care rendered by me and do not foresee any possibility of being able to pay the clinic service at any time m the future, or that there is not insurance or other pending claim to cover any part of amount owed to the clinic.

I hereby authorized to release information concerning the final diagnosis of each claim submitted to the McKinley County Health Care Board.

I declare that the above is true and correct and any false statement on this application constitutes a perjury and could result in denial of all claims submitted, a prison sentence and/or fine.

Signed this ______ day of____________________, ______

____
Applicant/Patient

Subscribed and Sworn to before me this _______ day

______________________, _______

____
Notary Public

My Commission Expires: ______________________

(SEAL)

McKinley County
Health Care Claims Program

Authorization to Release Medical and Financial Information

I, the undersigned, hereby authorize the release to the McKinley County Indigent Medical Claims Program of any medical, financial, or health information about me, or members of my immediate family, including the results of any laboratory tests, examinations, surgical procedures, final diagnosis and financial medical records.

This information is needed in connection with determination for assistance from the McKinley County indigent Medical Claims Program. It is understood that information thus obtained will be treated as confidential.

SIGNED ______________________________

DATE ______________________________

McKinley County Health Care Hospital Claims Fund Program

Certification Statement

Certification of Status of Applicant for Other Medical Assistance

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Reference Applicant:: ______________________________

Address: ______________________________

Telephone: ______________________________

I hereby certify that I have made inquiry into the status of this applicant for other medical assistance, and to the best of my knowledge this applicant is not entitled to, has not applied for, or is not applying for eligibility under another public or private medical assistance program.

______________________ SIGNATURE

______________________ DATE

______________________ HOSPITAL

______________________ PHONE NUMBER

Indicate by an "X" which of the various programs you have specifically checked. If not applicable, indicate by "N/A." If you have not checked with the program, indicate by "O."

__________ Medicare

__________ Medicaid

__________ Welfare

__________ Any Other

__________ Insurance Claim

McKinley County
County Health Care Claims Program

Hospital Statement

Hospital: ______________________________ Date: ______________________

This statement is to be filled out and submitted to the County Health Care Office after the patient has been released.

Statement is to be submitted only after insurance payment (Medical, Workman's Compensation, Hospital, Accident, Liability or any other) has been made.

LIST EACH CLAIM SEPARATELY

Patient Name	Date of Service	Diagnosis	Resulted from Accident or Injury?	Total Cost of Care	Less Pmt.	Balance	%75 of Balance

I hereby certify that the attached billing is true and correct copy of all medical and hospital charges respecting the statement for the patient and I hereby certify that the hospital has received no payment or reimbursement for this patient from other sources, agencies, persons or entities with respect to these services, if so they have been noted above.

I also certify that all efforts have been made to collect payment for hospital cost incurred, whether it be private pay or otherwise, before submitting claim to the County Health Care Claims Board.

____
Signed, Hospital Staff

____
Date

McKinley County
County Health Care Claims Program
Employment Verification

Date: ______________________

____

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____

RE: Applicants Name ______________________________

Dear Employer:

In order to establish eligibility for County Health Care Hospital Funds, the hospital staff is required to verify the Incomes of all applicants. The person identified above has informed us that he/she is now, or has within the past 12 months been employed by your firm. Your cooperation and prompt return of the information requested below will be appreciated and will benefit your employee. Such information will be held in confidence and used only by the McKinley County Health Care Medical Claims Office.

Please return to: ______________________________

____

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____

I, the undersigned, hereby authorize you to release my employment information to the above agency.

Signature: ______________________________

(FOR EMPLOYER'S USE ONLY)

DATES OF EMPLOYMENT: From: ______________________ To: ______________________

Employee's Year to Date Income including overtime. $____________

Hourly Rate..$____________

Part Time.. ____________

Full Time .... ____________

Temporary .... ____________

Permanent.. ____________

Number of Hours worked per week: ....Straight Time____________

....Overtime____________

Monthly Salary.......................................$____________

Paydays are: Monthly...........................$____________

Semi-Monthly ....$____________

Weekly ....$____________

Bi-Weekly.......................$____________

Current Employment Status ______________________________

Likelihood of Continued Employment ______________________________

Print Name ______________________ Signature ______________________

Title ______________________ Date ______________________