County of Lea
100 N. Main Street, Suite 11, 4th Floor
Lovington, NM 88260
(575)396-8657 * (575) 396-8699

Application instructions and checklist of documents:

1. Before completing the application read the Verified Statement, and sign it. Your signature will bind you to the provisions of the verified statement.

2. **General list of documents** (see below) must be sumbitted with your application.

Please answer all questions. List all members living within the same household, whether dependent or not. Provide social security numbers and dates of birth. If the patient or other member(s) of the household is undocumented, please provide birth certificates, marriage license, immigration documents or other legal documents that will assist in identifying the household unit and their status (MICA); any information that you are uncertain about can be verified during the review.

A notification will be given of any additional documents needed at the time of the submittance of your application.
Failure to provide any of the necessary documents will result in the denial of your application.

3. Proof of all insurance(s) and medical coverage (Medicare/Medicaid).

(Any information that you provide to determine eligibility will be held confidential, except as allowed by law and regulation).

General Listing - Provide the following documents

INCOME

1. Current Income tax return includes state/federal forms with all W'2's. If you did not file a tax return contact local office for further instructions.
2. Current check stubs verifying wages. Income can be wages earned or unearned as follows:

Social Security, Veterans, or Retirement benefits, Student Loans, Scholarships, Grants or other financial support, JTPA, Disability, Unemployment or Worker's Compensation, Supplemental Security Income (SSI), Welfare(akaTANF or SNAP).

RESIDENC Provide the following documents (Must have resided in county for 90 days prior to admission)

1. Rental Lease contract; property taxes; voters registration;school, church, or public agency documents

Non-related references (two) with name, mailing address and phone number.

ASSET

1. Checking/Savings account (bank statements); other investments such as stocks, bonds, CD's; Escrow accounts; Settlements; Inheritance; Divorce petitions and/or decrees, etc.

DEBTS

1. Please provide your recent utility bills such as electric, gas, water, also rental receipts or property taxes.

INDIGENT CRITERIA

1. Single - $16,346
2. Family - $24,519 - add an additional $1,500 for each eligible dependant when household exceeds two household members.

Note: Items required by each County may vary.

IDENTITY

Copy of Social Security Card and a picture ID

LEA COUNTY INDIGENT HEALTH CARE APPLICATION

First Name	Middle Name	Last Name	D.O.B.	SS #	Marital Status
Mailing Address	Date Moved In	City	State	ZipCode	Contact #

RESIDENCE VERIFICATION - Provide Information for 12 Months Prior of Admission

Address	Moved IN	Moved Out	Own/Rent/Rent Free	(specify proof provided)
Address	Moved IN	Moved Out	Own/Rent/Rent Free	Did You Provide Proof
Address	Moved IN	Moved Out	Own/Rent/Rent Free	Did You Provide Proof

HOUSEHOLD MEMBERS

Name	D.O.B.	S. S. #	Relationship	If an Adult is he/she employed? Need Proof

EMPLOYMENT - Provide Information for 12 Months Prior of Admission

Employee	Employer	Date Hired	Date Terminated	Monthly Salary	Does Applicant depend on this income?

OTHER INCOME - Provide Proof How The Applicant Support himself/herself Financially - **REQUIRED**

SPECIFY: **Unemployment, Pension, SS, VA Benefits, General Assistance, TANF, Education, Workers' Comp, FoodStamps, Contributions**

Type of Income	Monthly Amount	Since	Type of Income	Monthly Amount	Since
Type of Income	Monthly Amount	Since	Type of Income	Monthly Amount	Since

If Contribution is their source of Income, please complete a notarized contribution form

REFERENCES

Name	Phone #	Name	Phone #	Name	Phone #

OTHER LIABILITY - If admission was due to an injury, please complete below

Was the Admission due to an Injury	Type Of Injury	Location of Injury	Name of Liabililty Insurance	Liability Insurance Phone #	If MVA, did you obtain a Police Report

PUBLIC ASSISTANCE

Does your employer offer health insurance, if yes, did you enroll? if no, explain reason:

Did the Applicant apply for social security benefits, if yes, when and what is the current status?

ASSETS

Did the Applicant receive any type of settlement from social security, mortgage, pension etc. within the 12 months?

How Much Received: ____________ Date Funds Received: ____________ Who Received It: ____________

CHECKLIST: Indigent Representative Please Check Below to Confirm Application is Completed

- Residency for 12 Months ○
- Employment for 12 Months ○
- Income for 12 Months ○
- ○ Included Income for all Adults in the Household
- ○ Did Inquire How Many Bedrooms, if Applicant owns the home
- ○ Did You Get Signatures on the Hippa Documents

VERIFIED STATEMENT OF QUALIFICATION FOR LEA COUNTY HEALTH CARE

That I am the patient or the person having custody of the patient who has completed this application and verified the statement.

That there is no insurance to cover other than what was stated on this application.

That I will authorize the release of all medical records and/or financial records needed by the Lea County Health Care that will be utilized in processing my claim.

That I will authorize the contracted provider(s) and the 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.

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 servcies(s) to the Lea County Health Care.

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.

Signature ____________________ Date __________

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

The foregoing instrument was acknowledged before me this __________ day of ______

by ______________________________ .

Notary Public ________________ My Commission Expires: __________

COMMENTS: ______________________________

____

Name of party completing form(if other than patient)

REVISED 04/6/10

Relationship to Patient

Reason Applicant Unable to Sign

INCOME SUPPORT ASSISTANCE VERIFICATION

TO: INCOME SUPPORT DIVISION
2120 N ALTO SUITE D
HOBBS NM 88240

FROM: Sherry-Ann Baggoo, Lea County Indigent Claims Specialist

Applicant ______________________

S.S. #: ____________ **D .O. B.** ____________

VERBAL CONFIRMATION

Name of ISD Representative

______ **Date** ______ **Time**

Comments: ______________

____

Indigent Representative's Signature

(If case is closed but benefits were received within dates mentioned, please attach printout)

1. Has this patient applied for financial assistance? ______________
   A. Date applied for TANF: ______________

Attach printout of TANF received from ________ thru ________

   B. Date applied for Foodstamps: ______________

Attach printout of Foodstamps received from ________ thru ________

   C. Date applied for General Assistance: ______________

Attach printout of General Assistance received from ________ thru ________

   D. Reason for Denial: ______________

____

2. Has this person applied for medical assistance? ______________
   A. Type of assistance received: ______________
   B. Effective Date: ______________
   C. Other family members receiving medical coverage: ______________

____

____

   D. Reason for Denial: ______________

____

Information verified by : ______________

ISD Representative Signature Date

I hereby authorize release of this information to:

LEA COUNTY INDIGENT CLAIMS DEPARTMENT
100 N MAIN STREET, SUITE 11
LOVINGTON, NM 88260
(575)396-8657 or FAX (575)396-5684

______________ ______________

APPLICANT'S SIGNATURE **DATE**

SCHEDULE VIII

RESIDENCE VERIFICATION

TO: ______________________________ (LANDLORD)

FROM: LEA COUNTY INDIGENT HOSPITAL CLAIMS DEPARTMENT

RE: ______________________________ (TENANT)

TENANT'S ADDRESS: ______________________________

DATE MOVED IN: ______________ DATE MOVED OUT ______________

IS TENANT: BUYING, RENTING OR LIVING RENT FREE
DOES IT INCLUDE UTITLITIES? YES OR NO
AMOUNT OF PAYMENT: ______________ PER MONTH

I HEREBY AUTHORIZE THE RELEASE OF THIS INFORMATION TO THE LEA COUNTY
INDIGENT CLAIMS DEPARTMENT x ______________________________
APPLICANT'S SIGNATURE

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN FORM TO:

LEA COUNTY INDIGENT
ATTN: INDIGENT CLAIMS DEPARTMENT
100 N MAIN ST. SUITE 11
LOVINGTON, NM 88260
(575)396-8521 OR FAX (575)396-5684

VERIFIED BY: ______________________________
(LANDLORD'S SIGNATURE)

ADDRESS: ______________________________
(LANDLORD'S ADDRESS) (PHONE #)

STATE OF NEW MEXICO)
SS:
COUNTY OF LEA)

THE FOREGOING INSTRUMENT WAS ACKNOWLEDGED BEFORE ME THIS
__________ DAY OF ______________ BY ______________________________

____
NOTARY PUBLIC

MY COMMISSION EXPIRES: ______________________________

CONTRIBUTION VERIFICATION FORM

I'M SIGNING THIS DOCUMENT TO CONFIRM THAT I, ______________________________

CONTRIBUTE TO THE APPLICANT TO ASSIST IN PAYING FOR THE FOLLOWING:

_____	UTILITY BILLS	_______	Per Month	Since	______________
_____	RENT EXPENSE	_______	Per Month	Since	______________
_____	FOOD & SHELTER	_______	Per Month	Since	______________
	Total	0			

______________________________ , is my ______________
Applicant's Name Relationship

By signing this I declare the above verification is true and correct.

____
Signature

____
Date Signed

____
Contact #

THE FOREGOING INSTRUMENT WAS ACKNOWLEDGED BEFORE ME THIS
_____ DAY OF ______________ BY ______________________

______________________________ ______________________
NOTARY PUBLIC MY COMMISSION EXPIRES

Office Use Only

0.00 Annual Contribution

SCHEDULE III
EMPLOYMENT VERIFICATION FORM

TO EMPLOYER: ______________________________

FROM: LEA COUNTY INDIGENT DEPARTMENT

RE: ______________________________
(applicant's name)

EMPLOYEE: ______________________________

SS #: ____________________ D.O.B. ____________

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW AND RETURN TO:

LEA COUNTY FINANCE DEPARTMENT
ATTN: INDIGENT CLAIMS DEPARTMENT
100 N. MAIN STREET, SUITE 11
LOVINGTON, NM 88260

1. Employee Position: ______________________________
2. Date Employed: ______________________________
3. Date Terminated: ______________________________
4. 2012 YTD Gross Income: ______________________________
5. 2013 YTD Gross Income: ______________________________
6. Hours Averaged Per Week ______________________________
7. Hourly/Salary Rate ______________________________
8. Do You Offer Health Insurance? ______________________________
9. Is Claimant Enrolled? ______________________________
10. Reason Not Enrolled? ______________________________
11. Do You Offer Life Insurance? __________ Amount: ____________________

______________________________ ____________________
EMPLOYER'S REPRESENTATIVE SIGNATURE DATE

TO EMPLO
FROM:
RE:
EMPLOYEE
SS #:
1.
2.
3.
4.
5.