INFORMATION FOR THE APPLICANT

You may use this application to apply for the above programs. Please complete all the spaces on the application that pertain to you and your household members. If you need more space to answer any of the questions on this application, you may use the back of pages 3 and 4. If you have a spouse who wants to apply for the above programs, she/he also needs to complete an application. Please return the application(s) to the local Income Support Division (ISD) office.

There are other Medicaid programs that require a different application from this one.

If you qualify for one of the above programs, Medicaid will cover the following:

- Under the QMB program, you must have or be eligible for Medicare part A (Hospital Insurance). Medicaid will pay your Medicare premiums, deductibles, and co-insurance charges on Medicare covered services only. Medicaid will not cover dental, vision or prescription services.

- Under the SLIMB and QI1 program, you must have Medicare Part A. Medicaid will pay your Medicare Part B (Medical Insurance) premium only.

- Under the WDI program, you must be disabled and working, or have lost Supplemental Security Income (SSI) due to initial receipt of Social Security Disability Insurance (SSDI), and do not yet have Medicare. Medicaid will pay for all covered medical services. Small co-payments are required.

After the ISD office receives your application, you will have an interview. You will be asked to provide proof of the information needed to determine your eligibility.

Please see page 2 for YOUR RIGHTS and RESPONSIBILITIES.

APPLICANT:

Please keep this sheet for your records.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any public hearing, program or services, please contact the NM Human Services Department toll-free at 1-800-432-6217, or TDD 1-800-609-4TDD or through the New Mexico Relay System TDD at 1-800-659-8331. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (4/23/01)
MY RIGHTS AND RESPONSIBILITIES

Read carefully before completing the application.

BY SIGNING THIS APPLICATION, I AGREE TO THE FOLLOWING:

- To provide all information and proof needed to determine eligibility.
- To provide a Social Security Number for every household member who is applying for benefits.
- To permit the Human Services Department (HSD) to contact persons or agencies to verify needed information if I am not able to provide the information.
- To allow all information I give to HSD to be matched by computer with other federal, state, and local agencies.

HSD will use the information I give to decide on my eligibility, so the information must be as correct as possible.

If the information I report is false, incorrect, or incomplete, my benefits may be denied or ended.
- If I knowingly give false, incorrect or incomplete information, I may be prosecuted for that crime.
- I understand that I must pay back any benefits I am not eligible to receive.

FAIR HEARING RIGHTS - I understand I may request a fair hearing, either by telephone, in person, or in writing, within 90 days of the date the decision was made on my case. I may have another person represent me. I understand that if I do not agree with any decision made on any matter concerning my case, I have the right to look at my case record and other documents used to decide my case before the hearing.

CONFIDENTIALITY - All information I give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which I have applied. Confidential information may also be released to other agencies managing federal or federally funded programs. All information will be used to determine eligibility and/or to provide services.

PRIVACY - The information you give HSD will be used to determine whether your household is eligible or continues to be eligible to take part in HSD programs. We will check this information through computer matching programs. This information will also be used to make sure that you meet program rules and help us to manage the program. This information may be given to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of picking up persons fleeing to avoid the law. If you get benefits that you were not eligible for and have to pay them back, this is called a claim. If your household gets a claim against your household, the information on this application, including all Social Security Numbers, may be given to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including social security numbers of each household member is voluntary. However, each person applying for assistance must give a social security number or it will result in denial of program benefits to each individual applicant failing to give a social security number. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information or social security numbers. Any social security numbers given will be used and disclosed in the same manner as social security numbers of eligible household members. We also check with other agencies, the Federal Income and Eligibility Verification Service (IEVS), and the public assistance reporting information system (PARIS) about the information that you give us. This information may affect your household eligibility and benefit amount.

RESPONSIBILITY TO REPORT CHANGES - The information I give during the application process is used to determine eligibility. It is my responsibility to report changes within ten (10) days of the date of the change or as otherwise required. This includes changes in address, income, resources, health insurance, and persons living with me.

ASSIGNMENT OF RIGHTS TO PAYMENT - I understand that by getting Medicaid benefits, I automatically give HSD all rights to medical support and to payment for medical care from a third party. A third party can include an insurance company or another person who must pay for medical care and services. I understand that I must help HSD identify any third parties who may have to pay for medical care and services. I understand that if I do not help HSD, I may not get Medicaid benefits or may lose my benefits, unless I can show a good reason for not helping HSD.

RELEASE OF MEDICAL INFORMATION - By signing this application, I allow HSD to examine medical records needed for eligibility decisions and/or for payment of benefits.

YOUR CIVIL RIGHTS - All programs administered by the Human Services Department (HSD) are equal opportunity programs. If you believe you have been treated unfairly because of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual’s income is derived from any public assistance program, you may file a complaint. Complaints of discrimination may be filed with the New Mexico Human Services Department central office or the local Human Services county office. Complaints of discrimination about the SNAP/food program may be filed with the USDA, Director, Office of Civil Rights Room 326 W. Whitten Bldg., 1400 Independence Ave, S.W. Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). Complaints of discrimination about Cash Assistance and Medical Assistance programs may be filed with the Office of Civil Rights, Department of Health & Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202 or call (800) 366-1019 (voice) and (214) 767-8940 (TDD). 09/2/09
AGENCY USE ONLY

<table>
<thead>
<tr>
<th>Status</th>
<th>Former Recipient</th>
<th>Cat</th>
<th>Application Date</th>
<th>Date Mailed</th>
<th>Date Received</th>
<th>ISD Worker</th>
<th>Appointment Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Application</td>
<td>☐ Yes</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Recertification</td>
<td>☐ No</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PLEASE TELL US ABOUT YOURSELF AND YOUR SPOUSE.

NAME (Last, First, Middle)  
Date of Birth  
Fill out this section for each person only if they are asking for help  
Relationship  
Sex  
Race  
US Citizen  
Legal Alien  
Date of Entry Into U.S.

<table>
<thead>
<tr>
<th>Mo.</th>
<th>Day</th>
<th>Year</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LIST ALL CHILDREN WHO LIVE WITH YOU AND WHO ARE UNDER AGE 18.

DO YOU HAVE MEDICARE?  ☐ YES  ☐ NO

WHAT IS YOUR MEDICARE CLAIM NUMBER?
(Number listed on your Medicare card including letter code)

Have you received Medicaid under the Supplemental Security Income (SSI) Program?  ☐ YES  ☐ NO

If YES, when?  ________________________ to  ___________________________.

Are you receiving benefits under the Social Security Disability Insurance Program?  ☐ YES  ☐ NO

HOME ADDRESS and TELEPHONE NUMBER

House Number & Street OR Directions to Your Home  
Telephone or Message Number

City  
State  
Zip Code

MAILING ADDRESS (If it is different from your home address)

House Number & Street OR Directions to Your Home

City  
State  
Zip Code

Have you ever used other name(s)?  ☐ YES  ☐ NO  
If YES, list other name(s) used.

REPRESENTATIVE/GUARDIAN

Representatives Name  
Does this representative have:  ☐ Legal Guardianship  ☐ Power of Attorney

Representatives Address (House No. & Street OR P.O. Box)  
Telephone Number

City  
State  
Zip Code

INCOME (ALL MONEY RECEIVED) - List all income received by you, your spouse, and minor children living with you. Include income from work or job training, self-employment, alimony, government benefits (SSI, VA, etc.), royalties, pensions, and contributions from other persons or agencies. List the amount received before any deductions for taxes, insurance, Medicare, etc.

<table>
<thead>
<tr>
<th>Name of Person Working or Receiving Income</th>
<th>Name of Employer, Person, or Agency That Provides the Income</th>
<th>How Often Is Income Received?</th>
<th>Amount Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**RESOURCES - Vehicles** - List all cars, trucks, or other vehicles owned by you and/or your spouse.

<table>
<thead>
<tr>
<th>1) Year</th>
<th>Make</th>
<th>Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Year</td>
<td>Make</td>
<td>Model</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Year</td>
<td>Make</td>
<td>Model</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bank Accounts** - List name(s) of bank(s), account number(s), and amount(s) for all accounts that have your and/or your spouse's name.

<table>
<thead>
<tr>
<th>1) Bank Name</th>
<th>Account Number</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Bank Name</td>
<td>Account Name</td>
<td>Amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OTHER ASSETS** - List cash on hand, real property (other than your home), life insurance(s), royalties, burial funds, stocks, bonds, certificate(s) of deposit, IRA’s, trusts, livestock, and any other assets you and/or your spouse own.

<table>
<thead>
<tr>
<th>Name of Owner</th>
<th>Type of Resource</th>
<th>If you own life insurance, list the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Name of Company</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**WORK RELATED EXPENSES** – List any work-related expenses such as health insurance, transportation, or child care, etc. that are related to your disability.

<table>
<thead>
<tr>
<th>Type of Expense</th>
<th>To Whom is Expense Paid?</th>
<th>How Often is Expense Paid or Incurred?</th>
<th>Balance Owed for Expense (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL INSURANCE** - List any medical insurance coverage you and/or your spouse have.

<table>
<thead>
<tr>
<th>Person Covered</th>
<th>Name of Company</th>
<th>Policy Number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FOR WDI PROGRAM ONLY**

**APPLICATION for RETROACTIVE MEDICAL PAYMENTS**

Please read carefully

Do you have any unpaid bills for medical services received in the last three months? ☐ Yes ☐ No

If you do not understand the purpose of this section, please ask your worker to explain it to you. If you are approved for payment of retroactive medical bills, be sure to advise your doctor, hospital or other medical provider so that they can submit their bills for payment as soon as possible.

**YOU CAN REGISTER TO VOTE HERE**

If you are NOT registered to vote where you live now, would you like to register to vote here today? (Please check one) ☐ Yes ☐ No

If you do not check either box, you will be considered to have decided not to register to vote at this time. The National Voter Registration Act provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Important: Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

Signature Date

Confidentiality: Whether you decide to register to vote or not, your decision will remain confidential. If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Office of the Secretary of State, 419 State Capital, Santa Fe, NM 87503, (phone: 1-800-477-3632)

I have read all of the information in this application, or it has been read to me. This application is only for Medicaid.

I swear under penalty of law that the information I have given in this application is true, complete and correct to the best of my knowledge.

I give my permission to HSD to contact persons or agencies to obtain needed information about me.

I have been given my Medicaid rights and responsibilities.

<table>
<thead>
<tr>
<th>Applicant’s Signature</th>
<th>Date</th>
<th>Witness (if applicant signed with an X)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Person Who Helped complete the Application