



**OTERO COUNTY  
HEALTHCARE SERVICES**

**HEALTHCARE SERVICES FUND  
Serving the Residents of Otero County**

**Office Hours**

**Monday - Friday  
8:00am – 5pm**

Schedule may vary. Please call for appointment.

**575-437-7427**

**Room 222 – Ext. 12628**

**Room 220 – Ext. 12627**

**1101 New York Avenue  
Alamogordo, NM 88310**



## Otero County Healthcare Assistance Application Instructions

Application instructions:

1. **Please answer all questions.** List all persons living within the same household, whether they are dependents or not.
2. Before submitting the application, please read and sign the Verified Statement. Pursuant to NMSA §27-5-12(3), the Verified Statement of Qualification must be included in the application file. The statement shall constitute an oath of the person signing it, and any false statement in the statement made knowingly constitute a felony. These statements shall be made open to the public pursuant to NMSA §27-5-7(C). Refusal to sign the Verified Statement of Qualifications forms will result in automatic denial of assistance.
3. Please prepare to gather the necessary documentation for verification of eligibility. Examples are listed below for clarification. You should be ready to give as many facts as you can. If there are unresolved questions about your eligibility, you will be asked to give proof. A Healthcare Review Specialist will give you a list of everything you still need to give, along with a receipt for proof you provided. If you need help, ask a Healthcare Review Specialist.

Examples of Proof			
Residency	Driver License, State Issued Identification Card, Utility bills, Rent agreement, Property taxes, and/or current voter registration. <b>Must provide a 90 day reflection of Residency in Otero County.</b>		
Social Security Number	Social Security card or letter from the Social Security Administration (SSA) with your name & number		
Identity	You may give any of these if they prove identity, relationship or age: Driver's License, State Issued Identification card, Social Security card, Birth or baptism certificate(s), U.S. Passport, Citizenship/naturalization records, voter registration card, and certificate of Indian Blood (CIB).		
Relationship			
Age			
U.S. Citizen	U.S. Citizenship is required. For medical assistance, the federal government now requires that all individuals give certain ORIGINAL documents (not copies) that verify Citizenship, Identity or proof of Legal Permanent Status. Original documents will be copied and returned. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>Proof of Citizenship and ID together</b> A Passport A certificate of naturalization (Form 550 or N-570) A certificate of U.S. Citizenship (N-560 or N-561) A certificate of Indian Blood (CIB)</td> <td style="width: 50%;"><b>Proof of Citizenship Alone</b> U.S. birth certificate If you were born in New Mexico, Otero County Healthcare Services may be able to help you by checking with the Department of Health, Vital Records. Please give your caseworker your name, date of birth, county of birth, sex, mother's first and maiden name to get this help.</td> </tr> </table>	<b>Proof of Citizenship and ID together</b> A Passport A certificate of naturalization (Form 550 or N-570) A certificate of U.S. Citizenship (N-560 or N-561) A certificate of Indian Blood (CIB)	<b>Proof of Citizenship Alone</b> U.S. birth certificate If you were born in New Mexico, Otero County Healthcare Services may be able to help you by checking with the Department of Health, Vital Records. Please give your caseworker your name, date of birth, county of birth, sex, mother's first and maiden name to get this help.
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Income	<b>Earned Income:</b> Check-stubs, a letter from the employer with the hours you will work and the pay you will get. If you are <b>self employed</b> , you may provide a copy of your income tax forms, business records or personal wage records. <b>Unearned Income:</b> Copies of your check, or a letter from Social Security, Unemployment Compensation, Worker's Compensation, Veterans Administration, Bureau of Indian Affairs, Public Employees Retirement, IRAs, Student Loans, Scholarships, etc.  <b>Required:</b> Earned and Unearned income must reflect a 30-day period or all from the last month. Last year's Federal and State tax returns with all W-2s. If you did not file a return contact the Review Specialist for further instructions.		
Resources/Assets/Debts:	Checking/Savings account statements, other investments such as stocks, bonds, CDs, escrow accounts, settlements, inheritance, divorce petitions and/or decrees, etc.  This information must reflect 90 days prior to the treatment of patient(s) resources limit \$20,000.		
Health Insurance	ID card or letter from your insurance company Acceptance or Denial letter from Medicaid. <b>All applicants are required to attempt application for Medicaid Assistance.</b>		
Medicare Part A	ID card or letter from Social Security Administration		
Medical Bills	Any and all Medical Invoices incurred in which you are applying for payment assistance.		

\*Failure to provide any of the necessary documents will result in the denial of your application\*  
 (Any information that is provided to determine eligibility will be held confidential, except as allowed by law.)



## Otero County Healthcare Assistance Application

Office Use Only HHM: HHN:	Status: <input type="checkbox"/> Application <input type="checkbox"/> Redetermination	Former Recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No	Application Date:	Log Date:
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<b>PATIENT/CLAIMANT INFORMATION</b> If you need help filing in this application or obtaining information, please contact the Otero County Healthcare Services Dept. If you are applying for someone else, complete each section for that person. Proof of Identity is required.				
Legal Name (Last, First Middle):	Date of Birth:	Social Security Number:	Telephone Number:	
Street Address	City	County	State	Zip
<i>If your mailing address is different, please fill it in below. If not, please leave blank.</i>				
Street Address or P.O. Box	City	County	State	Zip
<i>Please list any physical address(es) you resided at within the past year.</i>				
Street Address or P.O. Box	City	County	State	Zip
Street Address or P.O. Box	City	County	State	Zip
Email Address:	Do you prefer email correspondence? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>Authorized Representative of Guardian</b> The authorized representative may or may not be the same individual designated as an authorized representative for the application processing or for meeting reporting requirements. The authorized representative designation must be made in writing.			
Do you want this person to: (check all the apply)			
<input type="checkbox"/> Apply for benefits upon your behalf? <input type="checkbox"/> Receive correspondence from the Otero County Healthcare Office?			
Name of Authorized Person(s)	Mailing Address	Preferred Telephone Number	Email Address

<b>RESIDENCY</b> Proof is required.			
Are you a resident of Otero County?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you intend to remain in Otero County?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Have you been a resident of Otero County for a minimum of ninety (90) days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Are you homeless?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you own a home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you rent a residence? List rent amount:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

List everyone that lives in your household. You only have to give U.S. Citizenship and Social Security Numbers for those household members that you are applying for assistance.									
Name (First and Last)	Relationship	Gender M/F	Date of Birth	Race/Ethnicity (optional)	SSN# (optional for non-applicants)	U.S. Citizen Y/N	Legal Immigrant Status? Y/N	Will you file federal income taxes for the current year? Y/N	Will you claim this person on your current year's tax return? Y/N
1.	(Self)								
2.									
3.									
4.									

Racial and ethnic data on participating households is voluntary, it will not affect the eligibility or the amount of benefits your household will receive. Native Americans are urged to identify themselves as such because Native Americans are entitled to certain special protections under the law. The reason we ask everyone for racial and ethnic information is to assure that benefits are distributed without regard to race, color, or national origin.

You have the right to file your application today, please do not delay. You can bring, mail or fax the application to the Otero County Healthcare office.

► Sign Here  \_\_\_\_\_ Today's Date \_\_\_\_\_

Please Answer the Following Questions About the People You Listed who are seeking eligibility with Otero County's Healthcare Assistance Program.			
List all individuals applying for assistance who have legal immigrant status and add information below.			
Who?	Document Type:	Id Number:	
Who?	Document Type:	Id Number:	
Who?	Document Type:	Id Number:	
Have you or anyone in your household sought Medicaid or Medicare eligibility?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was your Medicaid/Medicare eligibility denied or accepted? Please provide a copy of the denial/acceptance letter.		<input type="checkbox"/> Accepted	<input type="checkbox"/> Denied

Income:					
Note: If you are offered health insurance from any employer please fill out the Employer Coverage form attached to this application. Previous year's tax documents may be required for verification of yearly income.					
Have you or has anyone living with you received earned income or expect to receive income this month? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know					
If yes, please complete the chart below.					
Person with Income	Average number of hours worked?	Income From? (Work, self-employment, odd jobs, food stamps, VA Benefits, SSI, Workman's Comp., etc.)	How often Received? Yearly, Monthly, Biweekly, Weekly,	How much is received?	Does this employer offer Health Insurance? (Y/N) If yes, fill out the employer coverage form.

Additional Income:			
Examples of unearned income include, but are not limited to: Unemployment, Social Security, pensions, retirement, rental income, veteran's payments, child support, Indian monies, capital gains, dividends/interest, and per capita payments.			
Person with Income	Unearned Income From?	How Often Received? (Yearly, Monthly, Biweekly, Weekly, etc.)	How much do they receive?
			\$
			\$
			\$
			\$

Health Care Information:			
Please note that all applicants MUST apply for Medicare/Medicaid prior to approval of assistance from Otero County Healthcare Services. The letter of Medicare/Medicaid denial is required to be provided. Partial Medicaid coverage is considered a denial letter by the Otero County Healthcare Services.			
Has anyone in the household received medical services within the last 75 days that have not been paid?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list the members who have the bills and for which date. We may be able to help pay these bills.			
Family Member:	Hospital/Clinic	Date of Service	
Does anyone in your household have health insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please list all public and private health insurance including Medicare/Medicaid information for you and all people living with you.			
Persons Covered	Insurance Company Name	Medicare/Medicaid Claim Number or Insurance Member ID Number	Start Date

**Assets/Resources**  
 Certain resources/assets such as bank accounts may count toward your eligibility. Certain resources/assets may not count, such as a home and lot where you live and the resources of people who receive Supplemental Security Income (SSI).

Check all of the items that apply to you and all people living with you:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Cash on Hand    | <input type="checkbox"/> Checking Account   | <input type="checkbox"/> Livestock                | <input type="checkbox"/> CD – Certificate of Deposit |
| <input type="checkbox"/> Stocks or Bonds | <input type="checkbox"/> Retirement Account | <input type="checkbox"/> Recreation Vehicles      | <input type="checkbox"/> House/Land – Not Occupying  |
| <input type="checkbox"/> Savings Account | <input type="checkbox"/> Trust(s)           | <input type="checkbox"/> Life or Burial Insurance |  |
| <input type="checkbox"/> Other: -        |   | <input type="checkbox"/> Other -                  |  |

**Describe all of the items from above that are owned by you and all the people living with you:**

Item	Who Owns Them?	\$ Value	Bank or Company Name?
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

**Billing:**

List all bills and totals in which you are applying for assistance. Proof of bill is require.

Hospital/Clinic/Other Provider	Hospital/Clinic Account Number	Type of service(s)	Date of Service	Date of Discharge	Amount Paid by other source	Bill Total

**Your Signature (Your authorized representative may also sign here)**

Your signature makes this application valid and cannot be processed unless signed. Your signature also is an indication of the following:

- I understand that making false statements or hiding information could mean penalties and I have given Otero County Healthcare Services true, correct, and complete information.
- I am declaring the identity of the children under age 16 for whom I am applying.
- I will give proof of things I report to Otero County Healthcare Services. If I cannot get proof, I know that I can ask Otero County Healthcare Services to help me and I will let Otero County Healthcare Services contact other people, and companies to get proof.
- I will let Otero County Healthcare Services give limited information to approved agencies which give other related help for which I may be eligible.
- I understand that if I receive benefits for which I am not eligible, that I may have to pay Otero County Healthcare Services back for those benefits.
- I know that Otero County Healthcare Services will check the information that I give. Otero County Healthcare Services may use computers or other means to check the information on this form.
- I understand that I must cooperate with the Healthcare Review Specialist (HRS). HRS reviews cases to make sure we determine who can get help correctly.
- TRUSTS - I understand that if I, or the person(s) for whom I am applying, have set up a trust, or are the beneficiaries of a trust, I must give Otero County Healthcare Services a copy of the trust document, including all attachments and related information. Otero County Healthcare Services will analyze the trust to see if it affects the benefits for which I am applying.
- I understand that I must give Otero County Healthcare Services any money I receive for medical services which have already been paid. If I fail to do so, I, or the person(s) for whom I am applying, may lose eligibility coverage for at least one year AND until the amount owed to Otero County Healthcare Services has been paid back in full.

Applicant's Signature	Name of Witness (witness only if applicant signs by mark of thumbprint)	Date
Signature of Applicant's Representative	Name of Witness (witness only if applicant signs by mark of thumbprint)	Date

<b>Employer Coverage Form</b>			
If you are unemployed or retired, you do not need to fill out this section.			
<b>Employee Information</b>			
The employee needs to fill out this section. Write down the employee's information then you may request the information below from the employer. Use this completed form when you fill out an application for assistance from the Otero Health Care Assistance Fund.			
Employee Name (First Middle, Last)			Social Security Number
<b>Employer Information - Ask the employer for this information</b>			
Employer Name		Employer Identification Number (EIN)	
Employer Address		Employer Phone Number	
City	State	Zip Code	
Who can we contact about employee health coverage at this job?			
Name	Phone	Email	
<b>Tell us about the health plan offered by this employer.</b>			
<input type="checkbox"/> This employee is not eligible for coverage under this employer's plan.			
<input type="checkbox"/> The employee is eligible for coverage under this employer's plan.			(Start Date)
What is the name of the lowest cost self-only health plan this employee could enroll in at this job? (Only consider plans that meet the "minimum values standard" set by the Affordable care Act.)			
Name:			
<input type="checkbox"/> No Plans meet the "minimum value standard"?			
How much would the employee have to pay in premiums for that plan?			
\$	How Often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other -		

**Verified Statement of Qualification and Release of Information**  
**Otero County Health Care Review**  
**Pursuant to §24-5-12**

I attest that I am unable to pay the cost of the care administered, all assets owned are listed, and there is no insurance to cover my medical bills, other than what was stated on this application.

That I will authorize the contracted Provider(s) and Health Care Review Specialist(s) to make any inquiry of any person, firm, or corporation 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.

I, the patient, and/or the person applying on behalf, declare the above to be true and correct under penalty that any false statements made knowingly shall constitute a felony.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date