

VERIFICATION OF RESIDENCY: (non-related person)

The Health Plan Claims Office requests verification of residency for _____.

You were given as a reference by the applicant / patient for verification. Please provide us with the following information:

I verify that I have known _____ for the past _____ year(s).

The individual(s) live(s) at _____

located in _____ from _____ to _____.

Please list all the individuals living in the applicant/patient's household.

First Name / Last Name

First Name / Last Name

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If the individual(s) lived at more than one location, please list the address, location and dates below:

_____ from _____ to _____

_____ from _____ to _____

Signature: _____

Address: _____

Telephone: _____

Date: _____

PLEASE RETURN WITHIN 5 DAYS TO:

Grant County Health Plan Claims
1313 East 32nd Street
Silver City, New Mexico 88061

CASE NO: _____

GILA REGIONAL MEDICAL CENTER



Grant County Health Plan Program



GRANT COUNTY HEALTH PLAN OFFICE
 1313 East 32nd Street
 Silver City, New Mexico 88061

ELIGIBILITY DOCUMENT CHECKLIST

To qualify for the Grant County Health Plan, the following information must be brought to the Health Plan Office no later than 5 BUSINESS DAYS after this application is picked up. The submission of your application is not a guarantee of payment. Additional information may still be required by the County. It will be your responsibility to contact our office on the status of your claim.

A. PROOF OF ALL INCOME:

1. () Federal and State Tax Forms for year _____ and current year income
2. () General assistance Award Letters
3. () Food Stamps
4. () Unemployment check or letter
5. () Student Financial Aid Award Letter
6. () Notarized letter explaining income for the previous year stating the reason no income tax was filed. (How have you been supporting self for past 12 months?)
7. () 1099 Form for Social Security
8. () Current check for Social Security
9. () Pensions Year End Statement or Copy of Check
10. () Drivers license or Picture ID

A. PROOF OF ALL DEBITS:

1. () Rent Receipt
2. () House Payment
3. () Deed or Property Taxes
4. () Two (2) Current Utility (Example: Phone, Water, Light)
5. () Notarized letter if living rent free

Please return all of the above information to the GRMC Business Office or GRMC Financial Counselor located in the hospital no later than FIVE (5) BUSINESS DAYS.

1313 East 32nd Street • Silver City, New Mexico 88061 • (505)538-4000 Fax (505) 538-4178

VERIFICATION OF RESIDENCY: (Filled out by non-related person)

The Health Plan Claims Office requests verification of residency for _____.

You were given as a reference by the applicant / patient for verification. Please provide us with the following information:

I verify that I have known _____ for the past _____ year(s).

The individual(s) live(s) at _____

located in _____ from _____ to _____.

Please list all the individuals living in the applicant/patient's household.

First Name / Last Name	First Name / Last Name
_____	_____
_____	_____
_____	_____
_____	_____

If the individual(s) lived at more than one location, please list the address, location and dates below:

_____ from _____ to _____

_____ from _____ to _____

Signature: _____

Address: _____

Telephone: _____

Date: _____

PLEASE RETURN WITHIN 5 DAYS TO:
 Grant County Health Plan Claims
 1313 East 32nd Street
 Silver City, New Mexico 88061
 CASE NO: _____

COUNTY OF GRANT
Health Plans Fund Commissioner's Office
P.O. Box 898 / Silver City, New Mexico

APPLICANT INFORMATION

Account Number: _____

Name _____
Last First Middle Init. Other Names Used

Mailing Address Resident Address

Soc Sec # DOB Telephone

PATIENT INFORMATION

Name _____
Last First Middle Init. Other Names Used

Mailing Address Resident Address

Relation to Applicant DOB Soc Sec#

Citizenship of Patient

_____ U.S. Citizen

_____ NOT U.S. Citizen, BUT has been legally admitted

_____ NOT U.S. Citizen, AND has not been legally admitted

HOUSEHOLD: List all other members of the household.

Full Name	DOB	Soc Sec#	Relationship
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

RESIDENCY:

The Health Plan claim's patient for whom assistance is required

_____ is and has been _____ is and has not been

a resident of Grant County, New Mexico for ninety (90) days immediately prior to hospital/medical care.

The Health Plan claim's patient for whom assistance is requested is

_____ renting, sharing, or is supplied with a home free of charge by members of the family or friends.

_____ is buying or owns the home in which he/she lives.

EMPLOYMENT INFORMATION:

Name of Employed Persons	Employer	Gross Income
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER UNEARNED INCOME:

Source	Yes/No	Name	Amount	How Often
Social Security	_____	_____	_____	_____
VA Benefits	_____	_____	_____	_____
Military Allotment	_____	_____	_____	_____
Pension / Retirement	_____	_____	_____	_____
Scholarships/Grants/Loans	_____	_____	_____	_____
Workman's Compensation	_____	_____	_____	_____
Unemployment Benefits	_____	_____	_____	_____
Other unearned income	_____	_____	_____	_____
Loans	_____	_____	_____	_____

COUNTY OF GRANT
Health Plan Claims Fund

AUTHORIZATION FOR RELEASE OF INFORMATION / RECORDS

I hereby authorize the Revenue Division of the State of New Mexico and Federal Internal Revenue Service who would have information contained in my personal income tax return, my employer, my financial institutions, my landlord or any other person or agencies such as Social Security Administration, hospitals, doctors, Veterans Administration, schools, etc. who would have any information and/or records pertaining to past or present employment, past or present benefits, past or present financial status, and past or present residency, to release such information and/or records to the Grant County Health Plan Claims Fund for the purpose of determining my eligibility for a claim. I understand that Health Plan Claims Fund will make such contacts as are appropriate. A photocopy of the original Authorization to Release Information/Records to the Grant County Health Plan Claims Fund shall be sufficient for release of such records.

AUTORIZACION PARA RELEVAR INFORMACION/DOCUMENTOS

Yo, por este medio, autorio a la Division de Impuesto y Ingresos del estado de Nuevo Mexico y al Servicio Federal de Impuestos Internos, quien tendran informacion contenida en mi reporte de empuesto de ingreso personal, y tambien autorizo a mis patrones, instituciones dinacieras, propietario de casas, o cualquier otra personas o agencia tales como Administracions de Seguro Social, Hospitales, Doctores, Administracion de Veteranos, esquelas, etcetera quines tendran cualquier informacion o documentos nesessarios para que la Oficina de Reclamos de Fund Hospitalarios para Indigentes de Condado de Grant pueda determinar la eligibilidad de mi caso. Yo entiendo que la Oficina se pondra en contacto con las agencias o personas que se an aprendo. Una fotocopia de la autorizacion original bastara para relavar tales documentos y informacion a lasOficina de Reclamos de Fondos Hospitalarios para Indigentes de Condado de Grant.

SIGNATURE / FIRMA: X _____

ACKNOWLEDGEMENT

State of New Mexico)
County of Grant)

The foregoing instrument was acknowledged before me this _____ day of

_____, _____.

By: X _____

Notary Public

My Commission Expires

LIABILITY:

Was hospitalization / medical treatment a result of injury? _____ Yes _____ No

If yes, explain fully _____

Is there any medical coverage on the patient (medical, workman's compensation, hospital, accident liability or any other?) _____ Yes _____ No

If yes, explain fully _____

Is the patient eligible for: Medicare _____ Yes _____ No Medicaid _____ Yes _____ No

ASSISTANCE:

Are you, your spouse, or the patient receiving any welfare from New Mexico or from any other state?

_____ Yes _____ No

Have you, your spouse, or the patient recently applied for welfare assistance from New Mexico or from any other state?

_____ Yes _____ No

Have you, your spouse, or the patient ever received any welfare assistance in New Mexico?

_____ Yes _____ No

If yes, where _____ when _____ whose name _____

Have you, your spouse, or the patient ever applied or received assistance from an indigent hospital claims fund or similar organization?

_____ Yes _____ No

If yes, where _____ when _____ whose name _____

APPLICATION AND VERIFIED STATEMENT

STATE OF NEW MEXICO

COUNTY OF GRANT

VERIFIED STATEMENT OF QUALIFICATION FOR 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 Grant County Health Plan Claims Application.
2. That I have read the Grant County Health Plan Claims Application and know and understand the contents.
3. That the information that I have given in the Grant county health Plan Claims Application is true and correct.
4. That I, or the patient for whom I have legal responsibility, qualify as a patient under the provisions of the Grant County Health Plan 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 Gila Regional Medical Center in the amount of \$_____ or any part.
6. That I do not have insurance to cover any part of the above amount owed to the hospital other than cited previously in the completed application.
7. That I have listed all of my assets on the Grant county Health Plan Claims Application and that I do not have any property or sufficient assets which can be made subject to or assigned for payment of the 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 Grant County Health Plan Fund part or all of the fund money paid under this request.
9. That I do not have any claim or any other legal action, other than those cited previously in the completed application, pending against any party in regards to this case.

10. That I authorize release by Gila Regional Medical Center of any information concerning the final diagnosis and surgical procedure during the above hospitalization period to the Grant County Health Plan Claims Board. This may include psychiatric and/or psychological diagnosis. This authorization may include disclosure of alcohol and drug abuse diagnosis which is protected in the Code of Federal Regulations (42 CFR, part 2) and may include disclosure of HIV/AIDS diagnosis which is protected by provisions set forth in New Mexico House Bill 490 Chapter 227 "Human Immunodeficiency Virus Test Act" 1989. I understand such information will be used by the Board to perform utilization review and claims processing functions.
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 _____, _____.

X _____
Signature of Patient or person legally responsible for his/her care

SUBSCRIBED AND SWON TO before me this _____ day of

_____, _____.

Notary Public

My Commission Expires:

Person who helped to complete this application:

Signature: _____

Date: _____