



“We Work for the Health of Our Neighbors”

Grant County Health Plan

The Grant County Health Plan is a service provided by Grant County for its residents. It offers assistance with medical bills for services provided by Gila Regional Medical Center as well as ambulance transport, physical and occupational therapy at the Billy Casper Wellness Center. This includes some physician bills for services received in a Sole Community Provider hospital. The Grant County Health Plan will not cover medical supplies, medication or physician office visits outside of the hospital.

All applicants must supply proof of income for a period of twelve months prior to the date services were received. This can be the most recent Federal tax form, Social Security Benefit letter or another form of income proof. The applicant must also demonstrate proof of residency in Grant County for a 90 day period preceding the date of services. This can be three consecutive months of utility bills or notarized letters from two people who are not family members.

Once approved the applicant and eligible family members are considered current for one year from the application date. They must reapply at that time to maintain coverage with the GCHP.

Applicant's Information

Last Name	First Name	Middle Initial	Other Names Used
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Date of Birth	Social Security Number
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Mailing Address	Resident Address
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City	State	Zip Code	Phone Number
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Return to: Grant County Health Plan Office
 in the Registration area of Gila Regional Medical Center
 1313 East 32nd St. Silver City, NM 88061
 Phone: (575) 538-4180 (toll free 1-866-574-4989)
www.grmc.org

Annual Income Guidelines By Size of Household 2008	
1	\$20,800.00
2	\$28,000.00
3	\$35,200.00
4	\$42,400.00
5	\$49,600.00
6	\$56,800.00
7	\$64,000.00
8	\$71,200.00
9	For each additional person add \$7,200.00

Proof of income: 2007 Federal Tax Form
 Social Security Benefit Letter
 Other

Proof of Residency: 3 Consecutive Utility Bills
 2 Notarized Letters from Non-Family

Photo ID: Driver's License
 Other

List all members of the household who are applying for the GCHP coverage:

Full Name

SSN

Date of Birth

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Verified Statement of Qualification

I have been a resident of Grant County for greater than 90 days. The information I have provided with this Grant County Health Plan Claims Application is true and correct. I do not have any outstanding insurance or other resources to pay amount owed to my healthcare provider(s). If unforeseen resources should become available I will notify the Grant County Health Plan immediately and these resources will be applied to pay the Grant County Health Plan Fund part or all the fund money paid under this request. I do not have any claim or any legal action pending against any party in regards to this case.

I authorize the release of any information concerning the final diagnosis and surgical procedure to the Grant County Health Plan Claims Board. This may include psychiatric, psychological diagnosis, alcohol abuse, drug abuse and/or HIV/AIDS diagnosis. This information will be used to perform utilization review and claims processing functions.

I declare that all the information I have provided for this application is true and correct under penalty that any false statement made knowingly shall constitute a felony.

Signed _____ day of _____, 200__ .

X _____
Signature of Patient or Legally Responsible Party

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ day of _____, 200__ .

Notary Public

My Commission Expires