TAOS COUNTY INDIGENT FUND APPLICANT

- Taos County Indigent Fund Helps Pay For:
  - Hospital and ambulance bill(s)
- The Original Hospital Bill MUST EXCEED $200.00
- Ambulance Bills DO NOT need to exceed $200.00
- Taos County Indigent Fund DOES NOT PAY for:
  - Specialist, Medical Groups (Doctors), Dentist, Radiologists, Anesthesia, Prescriptions, or for –profit facilities; Heart Hospital of NM, PHI Air Medical or Tristate Careflight 5.
- Return the Indigent Application and Documentation to the Provider or the Indigent Office
  - Holy Cross Hospital, 1397 Weimer Rd, Taos, NM 87571
  - Taos County Indigent Department, 105 Albright St, Suite B, Taos NM 87571
    - Indigent Hours Monday-Thursday 8:00 am – 12:00 pm 1:00pm – 5:00pm Friday by appointment only

TO BE ELIGIBLE FOR TAOS COUNTY INDIGENT FUND ASSISTANCE:

1. Patient must have lived in Taos County three (3) months prior to the date of hospitalization or ambulance services
2. Gross Income for the last year cannot exceed: $32,091.00 for single - $48,136.00 for family
3. Liquid Assets cannot exceed: $10,000.00 for single - $20,000.00 for family
4. Initial claim must be filed within six (6) months following the hospital care.
5. All required documents must be submitted with Indigent Application

The following documentation must be returned with the Indigent Fund Application to determine eligibility: *affidavits should only be used when client is unable to provide the required*

1. Proof of Income – current check stubs, Social Security Award letter(s), Retirement, VA Benefits, Unemployment Award letter, etc; or if no income a Taos County Unemployment Verification (form Attached)
2. Liquid Assets – Bank Statements, Checking and/or Saving Accounts, Investments/stocks, bonds, certificates of deposit
3. Federal Income Tax Return – Federal Income Tax return forms for the prior year or if Tax Return not filed a Taos County Affidavit of Income (form attached)
4. Proof of Residency in Taos County – Rent lease/Contract, Mortgage Payment Stub, Utility letter with start date of service, Property Tax Notice (must have physical address on notice)
5. Provider(s) Billings – Hospital(s) bill(s), Ambulance(s) bill(s) – A Indigent Patient Declaration Statement and Affidavit will need to submitted with the every bill/claim.
6. Identification – Drivers License and/or INS Document/Visa
7. NM Human Service Department Verification – A letter from the NM Human Service Department (located at 45 Roy Rd, Taos, NM) verifying that the patient is not eligible for Medicaid Coverage

TAOS COUNTY INDIGENT HEALTH CARE PROGRAM

105 Albright Street, Suite B, Taos, New Mexico 87571
575-737-6435

APPLICATION FOR ASSISTANCE

1. Patient/Client Information *(Please print in INK or TYPE)* *Client ID #:*

Last Name: First Name: MI: Gender: ☐ F ☐ M

SSN: DOB: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Mailing: City: State: Zip:

Physical: City: State: Zip:

Home Phone: Work Phone: Message Phone:

2. Residency

Have you lived in Taos County for at least ninety (90) days prior to treatment dates? ☐ Yes ☐ No
Proof of residency must be submitted for each date of service.

US Citizen: ☐ Yes ☐ No *IF you are not a US Citizen, are you a legal permanent resident?* ☐ Yes ☐ No
If you are not a US Citizen or legal permanent resident, then please provide INS documents verifying status.

3. Household

List yourself and all household members related and/or non-related.

Full Name	DOB Required	SSN	Relationship	Legal Dependent Yes/No	Employer/Business Name *(include if self-employed)*
			self		

Total number of person(s) in household: *Please attach a separate sheet to report additional household members.*

4. Other Insurance and Liability

Medical Coverage: *Medicare, Medicaid, Indian Health Service (IHS or Contract Health), Private Insurance, Public Insurance or Medical program or assistance, Worker's Compensation, or any other medical resource.*

Does patient/client have medical coverage? ☐ Yes ☐ No
IF Yes, please specify: *Policy Number:*

Was health care/treatment a result of an accident? ☐ Yes ☐ No
IF Yes, where did accident occur? ☐ Home ☐ Work ☐ Auto *Please explain fully on a separate sheet.*

Are any liability claims or legal actions pending as a result of the accident? ☐ Yes ☐ No
IF Yes, Explain fully:

5. Public Assistance/Asset/Income

***A. Public* Assistance**

Does the household receive any of the following types of Public Assistance in Taos County? ☐ Yes ☐ No
☐ TANF $ ☐ Food Stamps $ ☐ Public Housing $ ☐ Tribal FA $ ☐ Other $
IF Yes, proof of Public Assistance must be submitted with this application.

Has the Patient/Client applied for medical assistance (Medicaid) through the NM Human Services Department? ☐ Yes ☐ No
IF Yes, Did you receive Approval/Denial letter? ☐ Yes ☐ No

B. Assets

Proof of Assets must be submitted with this application for all household members

Type/Source	Description	Yes/No	Owner of Asset	Value
Cash on Hand				
Checking Account				
Saving Account				
Investments/Stocks/Bonds				
Certificates of Deposit				
Land				
Other				

Please attach separate sheet to report additional sources of assets.

TAOS COUNTY INDIGENT HEALTH CARE PROGRAM

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APPLICATION FOR ASSISTANCE

C. Income

Did the Patient/Client or household member responsible for Patient/Client file a Federal and/or State income tax return last year? ☐ Yes ☐ No

IF Yes, a copy of your tax return(s) must be submitted with this application including verification of untaxed income such as Social Security.
IF No, Please explain why an income tax return was not filed.

Has there been any significant changes since your last year's tax return? ☐ Yes ☐ No

D. Income

Proof of income must be submitted with this application.

Source	Yes/No	Household Member Receiving Income	Year-to-Date Amount
Wages, Salaries, Tips			
Interest Income			
Alimony			
Business Income			
Capitol Gain			
IRA Distributions			
Pensions and Annuities			
Rental income			
Royalties/Partnerships/Trust			
Unemployment Compensation			
Social Security			
Child Support			
Other			

Please attach a separate sheet to report additional sources of income. Are there any adjustments to your gross income (in Section D) which should be considered? *IF Yes, Please explain on a separate attached sheet.*

STATE OF NEW MEXICO)
) ss.
COUNTY OF TAOS)

I, _____, having been duly sworn upon oath, depose and state as follows:

I understand that all information given by me in this application is subject to investigation and I authorize the Taos County Indigent Department and Holy Cross Hospital, Health Care Board, or its agents, to make any inquiry of any person, firm, association, or corporation to furnish any information relating to this application an/or verification statement without liability whatsoever.

I have read this application in its entirety and know and understand the contents therein. Under penalties of perjury, I declare to the undersigned entity that the information stated in the application is true and correct to the best of my knowledge.

Signed this _____ day of _____, _____.

_____
Signature of Patient/Client or Applicant

Subscribed and sworn to before me by _____

On this _____ day of _____, _____.

My Commission expires: _____

_____
Notary Public

Please attach separate sheet to report additional sources of assets.