UNM Sandoval Regional Medical Center, Inc.

SRMC Indigent Healthcare Assistance Program Application

This application will cover limited primary care visits, and does not cover any services received by independent physicians or clinics (Cardiac Care Consultants, ABQ Health Partners, and SW GI). SRMC covers Healthcare bills for necessary reasons at Sandoval Regional Medical Center only.

RETURN YOUR APPLICATION COMPLETELY FILLED OUT AND SIGNED, WITH THE FOLLOWING DOCUMENTATION FOR ALL HOUSEHOLD MEMBERS:

1. MOST RECENT BANK STATEMENTS
2. PICTURE I.D. /PROOF OF CITIZENSHIP(VALID DRIVER'S LICENSE/ID WITH CURRENT SANDOVAL CO. ADDRESS OR RESIDENT ALIEN CARD, CERTIFICATE OF NATURALIZATION, PASSPORT)
3. PROOF OF ANY AND ALL INCOME (FOR THE PAST 4 WEEKS) FROM ALL SOURCES INCLUDING THE FOLLOWING:
   A. ALIMONY
   B. CASH ASSISTANCE/SNAP BENEFITS AWARD LETTER
   C. CHILD SUPPORT
   D. CURRENT WAGES
   E. DISABILITY
   F. INCOME TAX FILING FOR THE HOUSE HOLD (ALL FORMS MUST BE INCLUDED)
   G. SIGNED LETTER OF FINANCIAL SUPPORT (ITEMIZED)
   H. SOCIAL SECURITY/RETIREMENT INCOME
   I. UNEMPLOYMENT BENEFITS
   J. VETERANS ADMINISTRATION
   K. WORKERS COMPENSATION
4. PROOF OF RESIDENCY IN SANDOVAL COUNTY: BILL WITH YOUR NAME, LETTER OF OCCUPANCY
5. PROOF OF SCHOOL ENROLLMENT (COLLEGE)
6. PROOF OF VEHICLE : INSURANCE/REGISTRATION/TITLE
7. SOCIAL SECURITY CARDS FOR ALL HOUSEHOLD MEMBERS
8. BIRTH CERTIFICATE
9. INSURANCE PREMIUMS/OPEN ENROLLMENT LETTER FROM EMPLOYER PROVIDED INSURANCE IF APPLICABLE

AT THE INTERVIEW YOUR COUNSELOR MAY REQUEST OTHER VERIFICATION TO DETERMINE YOUR ELIGIBILITY, AND MAY VERIFY ANY INFORMATION THAT AFFECTS YOUR ELGIBILITY. PROVIDE DOCUMENTATION FOR ALL HOUSEHOLD MEMBERS.PLEASE TURN IN YOUR APPLICATION WITHIN 90 DAYS FROM YOUR DISMISSAL DATE FOR ASSISTANCE ON YOUR SRMC HOSPTIAL BILL. PLEASE CALL 505-994-7397 TO MAKE AN APPOINTMENT.

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Date ______________________________ **Previous application made?** □ **YES** □ **NO**

General Information:

Name ____

(Last) **(First)** **(Middle Initial)**

Address ____ **Telephone #** (____)________________

Mailing Address if different ____

Marital Status: □ **Single** □ **Married** □ **Separated** □**Divorced** □**Widowed**

Email Address: ____

Where were you born: ____

Number of Household Members ________________(Total)

Household Member (Name)	Date of Birth	Age	Relation to Applicant	Occupation	Social Security #
	/ /		Self		
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

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Income: List all income sources for all household members such as Alimony, Child Support, Contributions, Disability, Employment Wages, Railroad Retirement, Social Security, Unemployment Compensation, Veteran's Pension, Worker's Compensation

Household Member	Employer or Type of Income	If Employed How Long	Supervisor	Hours Worked per Week	Monthly Gross Income

Receiving any financial support from family or friends? ____________________

How much? ____________ **How often?** ____________________

***Will need to provide a letter of financial support stating amount and how often received, signed by person providing support.**

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Buying/Rent/Own Home? ___________________ *** Living with friends or family? ___________**

Monthly Rent Payment	Monthly Mortgage Payment

***If living with friends or family, you will need to provide a detailed letter of occupancy signed by friend or family member.**

Utilities: Monthly Payment

Electric	Gas	Water

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<u>Personal Property:</u> Vehicles

Make	Model	Year	Value	Balance Due	Monthly Payment

<u>Bank Accounts:</u> Checking/Savings/Other Assets

Name of Bank	Account Number	Balance

Auto Insurance: ____________ **Health Insurance:** ____________ **Other Insurance:** ____________

Name of Insurance Company	Name of Insured Person	Monthly Premium

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I _________________________, certify that all of the information provided in this application is accurate and true to the best of my knowledge. This information is provided to Sandoval Regional Medical Center to determine my ability or inability to pay for services. I understand that all information provided by me is subject to verification. I also understand that any intentional misrepresentation of information may result in denial for assistance. I UNDERSTAND THAT THIS FINANCIAL ASSISTANCE PROGRAM IS NOT AN INSURANCE PLAN AND WILL APPLY TO MEDICAL CARE PROVIDED BY UNM MEDICAL GROUP PROVIDERS AND PROCEDURES AT SANDOVAL REGIONAL MEDICAL CENTER ONLY. I understand that must notify Sandoval Regional Medical Center if any of the following happens:

- **Move outside of Sandoval County (This program is for Sandoval county residents only)**
- **Obtain insurance coverage**
- **Receive an increase in income**

I understand failure to notify the financial assistance office of any changes will result in loss of eligibility for the program in which case I will be held responsible for all medical billings.

Name of Applicant: ______________________________ **Signature:**________________________________

Name of Spouse/Other Applicant:_________________________ **Signature:**_________________________

Date:______________________

FOR HOSPITAL USE ONLY:

Hospital Representative:____

Date:________________ **Approved/Denied**

Total Annual Income: _____________________ **Discount Level:** _________**%**

Expires:___________________________