Are You Worried about Paying Your Medical Bills? We May Be Able To Help

Please call our Financial Assistance Office at 994-7157 for an appointment.

This document can be translated into many languages upon request. We do have copies in Spanish. We can mail or give you a copy of the application or policy upon request. SRMC does not charge self pay patients more than we charge Government programs or Insurances.

In order for us to help you we need something to show your income and where you live. **You only need to bring the information that applies to your situation.** If you are approved, you may qualify for a discount of 70% or 100%. If you would like a copy or our Financial Aid Policy and application, it is located online at:
https://hsc.unm.edu/health/patients-visitors/financial-assistance/index.html
It is also available at UNM: SRMC 3001 Broadmoor Blvd NE, Rio Rancho, NM 87144

Proof Of Who You Are (Identity)

- Names, birthdates, and Social Security numbers if any for **yourself** and **all of your family members**, including children
- Birth Certificate and Social Security Cards (you **must** bring these if applying for Medicaid)
- Driver's License
- CIB (Certificate of Indian Blood) or other papers showing your tribal affiliation
- U.S. citizen papers
- Resident Alien Card (green card)
- Visa with permit
- Work permit **and** Social Security card
- Certificate of Naturalization
- Statement from someone who knows you and your situation

Proof Of Any Insurance

- Copy of Medicaid or Medicare Card
- Copy of health insurance card from work or the health exchange
- If you work and your employer does not provide insurance please bring a statement that says so

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Proof Of Income

Please provide any of these you have for **yourself, all family members, and anyone who lives with you:**

- If you work, copies of your last 4 check stubs or statement from your work showing your monthly income
- If you get Social Security, disability, veterans, pension, or other retirement, we need something showing the monthly payments
- If you are self- employed, we need something showing the monthly amount you earn.
- For other income please provide a statement from someone who knows your situation.

Proof Of Where You Live

Please provide something with your name and address on it:

- Utility bill
- Rental agreement
- Property tax bill
- Statement from someone who knows your living situation

Proof Of What You Own (Assets)

- (2) Bank account statements
- Stocks, bonds or other investments
- Property tax statement for any property you have other than your main residence (home)

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SRMC Care Financial Assistance Program Application

This application will cover bills from Sandoval Regional Medical Center, and does not cover any services received by independent physicians, hospitals, ambulance companies, diagnostic labs, or indepent clinics/practices (Cardiac Care Consultants, ABQ Health Partners, SW GI or any practice SRMC contracts with). SRMC Care 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:

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 DISCHARGE DATE FOR ASSISTANCE ON YOUR SRMC HOSPTIAL BILL. PLEASE CALL 505-994-7157 TO MAKE AN APPOINTMENT.

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Date _____ **Med Record number**_____

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.**

Income will be calculated based on the current months' pay: example

1 months' pay (previous month) multiplied by 12 months.
1 months' pay (previous month) multiplied by 13 weeks (if paid weekly) multiplied by 4

If income changes month to month, the Year to date will be calculated.

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. (If applicable)**

Utilities: Monthly Payment

Electric	Gas	Water

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Bank Accounts: Checking/Savings/Other Assets

Name of Bank		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 (PRINT) 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: _____

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LETTER OF SUPPORT

(If needed)

Date: _____

To UNM-Sandoval Regional Medical Center – Patient Financial Assistance Program:

I, _____, the undersigned do hereby certify that _____(Applicant) is unemployed with no income.

The client has no means of support other than the financial support I provide; or support in the form of room and board.

As supporter of the client, I provide $_____ for all basic needs, including but not limited to housing, utilities and food.

_____

__Signature of Supporter

_____

__Address

_____

__City/State and Zip Code

(I also understand that this does not make me responsible for any bills incurred by the applicant.)

Applicant: Please complete the following:

MONTH AND YEAR LAST WORKED: _____