



MEDICAID APPLICATION FOR
Qualified Medicare Beneficiaries (QMB)
Specified Low Income Medicare Beneficiaries (SLIMB)
Qualified Individuals 1 (QI)
Working Disabled Individuals (WDI)

INFORMATION FOR THE APPLICANT

You may use this application to apply for the above programs. Please complete all the spaces on the application that pertain to you and your household members. If you need more space to answer any of the questions on this application, you may use the back of pages 3 and 4. If you have a spouse who wants to apply for the above programs, she/he also needs to complete an application. Please return the application(s) to the local Income Support Division (ISD) office.

There are other Medicaid programs that require a different application from this one.

If you qualify for one of the above programs, Medicaid will cover the following:

- Under the **QMB** program, you must have or be eligible for Medicare part A (Hospital Insurance). Medicaid will pay your Medicare premiums, deductibles, and co-insurance charges on Medicare covered services only. Medicaid will not cover dental, vision or prescription services.
- Under the **SLIMB** and **QI1** program, you must have Medicare Part A. Medicaid will pay your Medicare Part B (Medical Insurance) premium only.
- Under the **WDI** program, you must be disabled and working, or have lost Supplemental Security Income (SSI) due to initial receipt of Social Security Disability Insurance (SSDI), and do not yet have Medicare. Medicaid will pay for all covered medical services. Small co-payments are required.

After the ISD office receives your application, you will have an interview. You will be asked to provide proof of the information needed to determine your eligibility.

Please see page 2 for YOUR RIGHTS and RESPONSIBILITIES.

APPLICANT:

Please keep this sheet for your records.



If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in **any public hearing, program or services**, please contact the NM Human Services Department toll-free at 1-800-432-6217, or TDD 1-800-609-4TDD or through the New Mexico Relay System TDD at 1-800-659-8331. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (4/23/01)

MY RIGHTS AND RESPONSIBILITIES

Read carefully before completing the application.

BY SIGNING THIS APPLICATION, I AGREE TO THE FOLLOWING:

- To provide all information and proof needed to determine eligibility.
- To provide a Social Security Number for every household member who is applying for benefits.
- To permit the Human Services Department (HSD) to contact persons or agencies to verify needed information if I am not able to provide the information.
- To allow all information I give to HSD to be matched by computer with other federal, state, and local agencies.

HSD will use the information I give to decide on my eligibility, so the information must be as correct as possible.

If the information I report is false, incorrect, or incomplete, my benefits may be denied or ended.

- If I knowingly give false, incorrect or incomplete information, I may be prosecuted for that crime.
- I understand that I must pay back any benefits I am not eligible to receive.

FAIR HEARING RIGHTS - I understand I may request a fair hearing, either by telephone, in person, or in writing, within 90 days of the date the decision was made on my case. I may have another person represent me. I understand that if I do not agree with any decision made on any matter concerning my case, I have the right to look at my case record and other documents used to decide my case before the hearing.

CONFIDENTIALITY - All information I give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which I have applied. Confidential information may also be released to other agencies managing federal or federally funded programs. All information will be used to determine eligibility and/or to provide services.

RESPONSIBILITY TO REPORT CHANGES - The information I give during the application process is used to determine eligibility. It is my responsibility to report changes within ten (10) days of the date of the change or as otherwise required. This includes changes in address, income, resources, health insurance, and persons living with me.

ASSIGNMENT OF RIGHTS TO PAYMENT - I understand that by getting Medicaid benefits, I automatically give HSD all rights to medical support and to payment for medical care from a third party. A third party can include an insurance company or another person who must pay for medical care and services. I understand that I must help HSD identify any third parties who may have to pay for medical care and services. I understand that if I do not help HSD, I may not get Medicaid benefits or may lose my benefits, unless I can show a good reason for not helping HSD.

RELEASE OF MEDICAL INFORMATION - By signing this application, I allow HSD to examine medical records needed for eligibility decisions and/or for payment of benefits.

CIVIL RIGHTS STATEMENT - All programs administered by HSD are equal opportunity programs. It is unlawful for HSD to discriminate against an applicant for or recipient of any program due to race, color, national origin, sex, age, religion, political beliefs, or disability. Complaints of discrimination may be filed with the New Mexico Human Services Department central office, the local Income Support Division County office, the U.S. Department of Health and Human Services, the U.S. Department of Justice, or the Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD).

AGENCY USE ONLY

Status <input type="checkbox"/> Application <input type="checkbox"/> Recertification	Former Recipient <input type="checkbox"/> Yes <input type="checkbox"/> No	Cat	Application Date	Date Mailed	Date Received
ISD Worker			Appointment Date		Time

PLEASE TELL US ABOUT YOURSELF AND YOUR SPOUSE.

NAME (Last, First, Middle)	Date of Birth			Social Security Number	Relationship	Sex	Race	US Citizen		Legal Alien		Date of Entry Into U.S.
	Mo.	Day	Year					Yes	No	Yes	No	
					Self							
					Spouse							

LIST ALL CHILDREN WHO LIVE WITH YOU AND WHO ARE UNDER AGE 18.

NAME (Last, First, Middle)	Date of Birth (Mo., Day, Year)	Social Security Number	Relationship	Sex	Race	US Citizen (Yes/No)	Legal Alien (Yes/No)	Date of Entry Into U.S.

DO YOU HAVE MEDICARE? SÍ NO

WHAT IS YOUR MEDICARE CLAIM NUMBER?

(Number listed on your Medicare card including letter code)

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Have you received Medicaid under the Supplemental Security Income (SSI) Program? YES NO

If YES, when? _____ to _____.

Are you receiving benefits under the Social Security Disability Insurance Program? YES NO

HOME ADDRESS and TELEPHONE NUMBER

House Number & Street OR Directions to Your Home	Telephone or Message Number
City	State Zip Code

MAILING ADDRESS (If it is different from your home address)

House Number & Street OR Directions to Your Home
City State Zip Code

Have you ever used other name(s)? YES NO If YES, list other name(s) used.

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REPRESENTATIVE/GUARDIAN

Representatives Name	Does this representative have: <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Power of Attorney
Representatives Address (House No. & Street OR P.O. Box)	Telephone Number
City	State Zip Code

INCOME (ALL MONEY RECEIVED) - List all income received by you, your spouse, and minor children living with you. Include income from work or job training, self-employment, alimony, government benefits (SSI, VA, etc.), royalties, pensions, and contributions from other persons or agencies. List the amount received before any deductions for taxes, insurance, Medicare, etc.

Name of Person Working or Receiving Income	Name of Employer, Person, or Agency That Provides the Income	How Often Is Income Received?	Amount Received

RESOURCES - Vehicles - List all cars, trucks, or other vehicles owned by you and/or your spouse.

1) Year	Make	Model	2.) Year	Make	Model	3.) Year	Make	Model

Bank Accounts - List name(s) of bank(s), account number(s), and amount(s) for all accounts that have your and/or your spouse's name.

1) Bank Name	Account Number	Amount	2) Bank Name	Account Name	Amount

OTHER ASSETS - List cash on hand, real property (other than your home), life insurance(s), royalties, burial funds, stocks, bonds, certificate(s) of deposit, IRA's, trusts, livestock, and any other assets you and/or your spouse own.

Name of Owner	Type of Resource	If you own life insurance, list the following:			
		Name of Company	Policy Number	Face Value	Cash Value

WORK RELATED EXPENSES – List any work-related expenses such as health insurance, transportation, or child care, etc. that are related to your disability.

Type of Expense	To Whom is Expense Paid?	How Often is Expense Paid or Incurred?	Balance Owed for Expense (If applicable)

MEDICAL INSURANCE - List any medical insurance coverage you and/or your spouse have.

Person Covered	Name of Company	Policy Number	Effective Date

FOR WDI PROGRAM ONLY

APPLICATION for RETROACTIVE MEDICAL PAYMENTS PLEASE READ CAREFULLY
 Do you have any unpaid bills for medical services received in the last three months? Yes No

If you do not understand the purpose of this section, please ask your worker to explain it to you. If you are approved for payment of retroactive medical bills, be sure to advise your doctor, hospital or other medical provider so that they can submit their bills for payment as soon as possible.

YOU CAN REGISTER TO VOTE HERE

If you are **NOT** registered to vote where you live now, would you like to register to vote here today? YES NO (**Please check one**)
 If you do not check either box you will be considered to have decided not to register to vote at this time. The National Voter Registration Act provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. **IMPORTANT:** Applying to register or declining to register to vote **WILL NOT AFFECT** the amount of assistance that you will be provided by this agency. Whether you decide to register to vote or not, your decision will remain confidential. If you believe that someone has interfered with your right to register or decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or political preference, you may file a complaint with the Office of the Secretary of State, 419 State Capitol, Santa Fe, NM 87503, (phone: 1-800-477-3632).

I have read all of the information in this application, or it has been read to me. This application is only for Medicaid.

I swear under penalty of law that the information I have given in this application is true, complete and correct to the best of my knowledge.

I give my permission to HSD to contact persons or agencies to obtain needed information about me.

I have been given my Medicaid rights and responsibilities.

Applicants Signature	Date	Witness (if applicant signed with an X)
Signature of Person Who Helped complete the Application		