



MEDICAID APPLICATION FOR WOMEN, CHILDREN, AND FAMILIES

INFORMATION FOR THE APPLICANT

Please complete all the spaces on the application about you and your household members. If more space is needed to answer any of the questions on this application, you may use another sheet. Return the application to the local Income Support Division (ISD) office or to the person who is determining your temporary Medicaid eligibility.

This is an application for the four medical assistance programs listed below. There are other Medicaid programs that require an application different from this one.

To qualify for medical assistance, your household must meet certain guidelines. You may be eligible for benefits for up to three months before your application date. You may ask about these guidelines by contacting the ISD office, or by calling toll free 1-888-997-2583.

- **JUL MEDICAID** provides Medicaid to parents or caretaker relatives with dependent children under age 19, even if the household does not qualify for cash assistance, or does not wish to apply for cash assistance. Medicaid is totally separate from cash assistance, and **receiving Medicaid benefits will not count toward the cash assistance time limit.**
- **MEDICAID FOR CHILDREN** provides coverage for children under age 19. Some children may be eligible under the State Children's Health Insurance Program (SCHIP). SCHIP children have small co-payment requirements. Native American children who are eligible for SCHIP do not make co-payments.
- **MEDICAID FOR PREGNANCY-RELATED SERVICES ONLY** covers only those services that are related to the pregnancy. Coverage for these services are provided for up to two months after the month in which the child is born or the pregnancy ends.
- **MEDICAID FOR FAMILY PLANNING SERVICES** covers only those services that are related to family planning for women between the ages of 18-50 years.

You need to provide proof of the following:

- Identity and citizenship or immigrant status.
- Income for the past four weeks.
- Social Security Number (SSN), or proof of application for SSN.
- Children's ages.
- Other health insurance, if any.
- Pregnancy due date.

If you need help filling in this application or in getting the needed information, contact your local ISD office.

After your application is received, all documents will be reviewed. If the documents are incomplete, you will be asked to provide the needed information. A decision on your application will be made within 45 days, unless you ask for more time to get information. You will be sent a letter about your application.

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 for myself and/or other persons, 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 absent parent, an insurance company, or another person who must pay for medical care and services.

I understand that I must help HSD:

- Identify the father of a child who gets Medicaid and who was born outside of marriage, and
- 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).

Income – List all money received by people in your household. This includes: money from job training or work, self-employment, government benefits (SSA, VA, etc.), alimony, royalties, pensions, trusts, investments, property income, child support, unemployment, and any other earned or unearned money from any source.

Name of Person Receiving Money	Name of Employer, Person, or Agency Providing the Money	How Often is the Money Received	Total Amount (before deductions)

DEPENDENT CARE

Do you pay anyone to care for a child or other household member, so you can work or train for a job? Yes No
 Who is being cared for?
 1. _____ 2. _____ 3. _____

Who Provides the Care?	Amount Paid	How Often is the Amount Paid?

COMPLETE THIS SECTION ALSO IF YOU ARE APPLYING FOR PRESUMPTIVE ELIGIBILITY

Are you or your child(ren) receiving Medicaid now? Yes No
 If yes, tell the agency or doctor you or your child(ren) already have Medicaid and show your Medicaid Card.

If you or a household member are pregnant, has presumptive eligibility been granted for this pregnancy? Yes No
 If Yes, you are not eligible for presumptive eligibility for the remainder of this pregnancy.

Has your child(ren) received presumptive eligibility within the last twelve months? Yes No
 If yes, your child(ren) is not eligible for presumptive eligibility.

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 not 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 affirm under penalty of perjury that the statements made about persons in my home, income, and my declaration of identity for the child(ren) for whom I am applying and all the other information I have given HSD are true and correct. 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.

 Applicant's Signature

 Date

 Signature of Person Who Helped Complete the Application

 Witness (if applicant signed with an X)