HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

INTRADEPARTMENTAL MEMORANDUM
MAD-MR: 15-24
DATE: 12/30/2015

TO: **ISD AND MAD STAFF**

FROM: **NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISON**
MARILYN MARTINEZ, DIRECTOR, INCOME SUPPORT DIVISION

THROUGH: **ROY BURT, BUREAU CHIEF, ELIGIBILITY BUREAU**

BY: **RICHARD MCINTYRE, ELIGIBILITY BUREAU**

SUBJECT: **REVISED APPLICATION FOR MEDICAL ASSISTANCE MAD 100**

GENERAL INFORMATION

The Application for Medical Assistance (MAD 100) has been updated. The Forms Manual in each Income Support Division office should be updated to contain the most current version.

FILING INSTRUCTIONS

1. Remove all previous versions from inventory:

   Application for Medical Assistance MAD 100 revised 03/20/2014

2. Replace with revised form:

   Application for Medical Assistance MAD 100 revised 12/31/2015

Please address questions concerning this MR to Richard.McIntyre@state.nm.us or call (505) 476-6818.

Application for Medical Assistance
Information Sheet

New Mexico Human Services Department (HSD)

- Medicaid provides free or low-cost health coverage for certain low-income individuals and families.
- Depending on your household income, some household members may qualify for full or limited Medicaid coverage.

You can apply for Medicaid online at:

www.yes.state.nm.us

Or call 1-855-635-6574

Or take your signed application to your local Income Support Division (ISD) office

Or mail your signed application to:

Central ASPEN Scanning Area (CASA)
PO Box 830
Bernalillo, NM 87004

Or fax your signed application to 1-855-804-8960

New Mexico Health Insurance Exchange (NMHIX)

- The NMHIX is a way to shop for and compare health insurance plans for individuals and families who are not eligible for Medicaid.
- You or your household may qualify for a program that can help you pay for health insurance, even if you earn as much as $92,000 a year (for a family of four).
- Tax subsidies that can immediately help pay your premiums for health coverage may be available.

You can apply for affordable health insurance online through the NMHIX at:

www.bewellnm.com

Or call 1-855-996-6449
TTY: 1-855-889-4325

Medical Assistance Programs	
MEDICAID	Depending on your household income, some household members may qualify for full or limited Medicaid coverage. The following are some types of Medicaid that household members may qualify for: • Newborn • Children through age 18 • Parent(s)/Caretaker(s) • Pregnant women • Low-income adults • Emergency Medical Services for Aliens (EMSA)
NM HEALTH INSURANCE EXCHANGE	The NMHIX is a way to shop for and compare health insurance plans for individuals and families who are not eligible for Medicaid. If you do not qualify for Medicaid, you or members of your household may be eligible to receive a tax subsidy that can immediately help pay for health insurance premiums. If you or members of your household do not qualify for Medicaid, your application will be automatically sent to the NMHIX, where you or members of your household may be found eligible for other health insurance affordability programs.

Tell us if you need: ❑ Help filling out this application ❑ Free language help Preferred language: ❑ I don't have transportation ❑ Disability accommodation

1. Tell Us About You. If you need help filling out this application or getting the needed information, contact your local ISD office. If you are applying for someone else, complete this section for that person.

First Name, Middle Initial, Last Name	Date of Birth		Best Time to Contact You	
Street Address	City	County	State	Zip Code
E-Mail Address	Telephone Number		Alternative Telephone Number (optional)	

If your mailing address is different, please fill it in below. If not, please leave address blank.

Mailing Address (if different)	City	State	Zip Code
Are you a resident of New Mexico? ❑ YES ❑ NO	Do you intend to remain in New Mexico? ❑ YES ❑ NO	Are you homeless? ❑ YES ❑ NO	
Do you want to receive information electronically? ❑ YES ❑ NO If **yes**, please fill out your e-mail address above.			

2. Person to Represent You (Authorized Representative or Guardian). Your authorized representative can be a person who has helped you apply for or renew benefits, or it can be a different person. If you want to have an authorized representative, you must tell us who that person is in writing, below.

Name of Authorized Person(s)	Mailing Address	Preferred Telephone Number or TDD

3. Tell Us About the People Who Live With You and/or Individuals on Your Federal Income Tax Return.

Please list everyone who lives in your household, even if you do not want to apply for them. You only have to give US citizenship and Social Security Numbers (SSNs) for household members who are applying for assistance. An SSN is optional for people who are not applying for medical assistance, but providing an SSN can speed up the application process. You do not need to be a US citizen or file income taxes to apply. Receiving medical assistance will not prevent you from becoming a lawful permanent resident or US citizen. Non-citizen immigrants who are not requesting assistance for themselves do not need to give immigration status information, SSNs or other similar proofs; however, they must give information about their income because part of their income may count toward the household's eligibility for assistance. Certain medical assistance programs may be available for people without an SSN; ask ISD. Racial and ethnic data on applicant households is voluntary; it will not affect your eligibility or the amount of benefits your household may receive. Native Americans are urged to identify themselves as such because Native Americans are entitled to certain special protections under the law. We ask everyone for racial and ethnic information to assure that benefits are distributed without regard to race, color or national origin. If you need more space, please use an additional sheet of paper.

List the names and information for yourself and the people who live with you, and for anyone who you include on your federal income tax return:					**This section is only required for each person applying for medical assistance:**				
Name (First and Last)	Relationship	Applying for Medical Assistance? Yes/No	Sex M/F	Date of Birth	Ethnicity: Hispanic Yes/No (optional)	Race: 1-6 See below (optional)	Tribal Affiliation	Social Security Number (SSN) – required **if you have one** (optional for non-applicants)	Citizenship or Immigration Status 1-22 See below
	(Self)	❑ YES ❑ NO							
		❑ YES ❑ NO							
		❑ YES ❑ NO							
		❑ YES ❑ NO							
		❑ YES ❑ NO							
		❑ YES ❑ NO							
		❑ YES ❑ NO							
		❑ YES ❑ NO							

Race: For each person applying for assistance, choose the number(s) below that best describes their race and write the number(s) above.

1 – American Indian/Alaska Native	4 – Native Hawaiian or Pacific Islander
2 – Asian	5 - White
3 – Black or African American	6 - Other

Citizenship or Immigration Status: For each person applying for assistance, choose the number(s) below that best describes their US citizenship or immigration status and write the number(s) above.

1 – U.S. Citizen	7 – Paroled into the US	13 – Deferred Enforced Departure	19 – Applicant for asylum
2 – Lawful Permanent Resident (LPR)	8 – Conditional entrant granted before 1980	14 – Deferred Action Status	20 – Registry applicant with Employment Authorization Document (EAD)
3 – Lawful Temporary Resident (LTR)	9 – Battered spouse, parent or child	15 – Granted withholding of deportation or withholding of removal	21 – Order of Supervision (with EAD)
4 – Asylee	10 – Victim of trafficking and his/her spouse, child, sibling or parent	16 – Applicant for withholding of deportation or withholding of removal	22 – Applicant for cancellation of removal or suspension of deportation (with EAD)
5 – Refugee	11 – Individual with non-immigrant status (includes worker/student visa, and citizens of Micronesia, the Marshall Islands and Palau)	17 – Applicant for special immigrant juvenile status	23 – Other/Unsure
6 – Cuban/Haitian entrant	12 – Temporary Protected Status or applicant for Temporary Protected Status	18 – Applicant for adjustment to LPR status, with approved visa petition	

4. Tax Filing Information. Please give the following information for every household member applying for medical assistance, even if the tax payer or tax dependent is not in your home. You do not need to file income taxes to apply.

A Name	B Does this person plan to file a federal income tax return next year?	C Will this person file jointly with a spouse/partner?	D Does this person have any tax dependents?	E Is this person claimed as a tax dependent on someone else's tax return?	F How is this person related to the tax filer?
	❑ YES ❑ NO	❑ YES ❑ NO If **yes**, name of spouse or partner:	❑ YES ❑ NO If **yes**, name(s) of dependents:	❑ YES ❑ NO If **yes**, name of the tax filer:	
	❑ YES ❑ NO	❑ YES ❑ NO If **yes**, name of spouse or partner:	❑ YES ❑ NO If **yes**, name(s) of dependents:	❑ YES ❑ NO If **yes**, name of the tax filer:	
	❑ YES ❑ NO	❑ YES ❑ NO If **yes**, name of spouse or partner:	❑ YES ❑ NO If **yes**, name(s) of dependents:	❑ YES ❑ NO If **yes**, name of the tax filer:	
	❑ YES ❑ NO	❑ YES ❑ NO If **yes**, name of spouse or partner:	❑ YES ❑ NO If **yes**, name(s) of dependents:	❑ YES ❑ NO If **yes**, name of the tax filer:	
	❑ YES ❑ NO	❑ YES ❑ NO If **yes**, name of spouse or partner:	❑ YES ❑ NO If **yes**, name(s) of dependents:	❑ YES ❑ NO If **yes**, name of the tax filer:	
	❑ YES ❑ NO	❑ YES ❑ NO If **yes**, name of spouse or partner:	❑ YES ❑ NO If **yes**, name(s) of dependents:	❑ YES ❑ NO If **yes**, name of the tax filer:	

5. Please Answer the Following Questions About the People You Listed in Section 3. For household members applying for benefits who are not US citizens, please give the information that appears on their immigration documents. This will be used to see who might be eligible for benefits. If you do not know the information below, show your immigration document to ISD. If you need more space, please attach another piece of paper.

Name	Immigration Document Type	Alien or I-94 Number	Card Number or Passport Number	SEVIS ID or Expiration Date (optional)	Other (category code or country of issuance)	Lived in the US Since 1996?	Is this person a spouse or parent of a veteran or on active duty with the US military?
						❑ YES ❑ NO	❑ YES ❑ NO
						❑ YES ❑ NO	❑ YES ❑ NO
						❑ YES ❑ NO	❑ YES ❑ NO
						❑ YES ❑ NO	❑ YES ❑ NO

Is any applicant getting Medicaid in another state?	❑ YES ❑ NO If **yes**, who? Which state?
Is any household member age 21 or younger and a full-time student?	❑ YES ❑ NO If **yes**, who?
Is any applicant imprisoned (detained or jailed)?	❑ YES ❑ NO If **yes**, who? What facility? Date of imprisonment: Date of release (if known):
Is any applicant in the household receiving Supplemental Security Income (SSI)?	❑ YES ❑ NO If **yes**, who?
Was any applicant ever in foster care?	❑ YES ❑ NO If **yes**, who? Which state?
Is any applicant disabled?	❑ YES ❑ NO If **yes**, who?
Is any applicant already in or going into a nursing home, hospital or treatment facility?	❑ YES ❑ NO If **yes**, who?
If yes, what type of facility?	❑Nursing home/nursing facility ❑Hospital ❑ PACE ❑ Intermediate Care Facility for the Intellectually Disabled ❑ Other, where?
Is any applicant pregnant?	❑ YES ❑ NO If **yes**, who? Due date (if known): Number of babies expected from this pregnancy (if known):
Has any applicant received a Primary Freedom of Choice letter for a Home and Community-Based Services Waiver?	❑ YES ❑ NO If **yes**, who?

6. Tell Us About Your Earned Income. Please report your total income **before** taxes. If you are applying for medical assistance and you are offered insurance from any employer, please fill out the Employer Coverage Form attached to this application. Failure to complete this form will not delay your application for assistance.

Have you or anyone living with you received earned income or expect to receive earned income this month?				❑ YES ❑ NO ❑ DON'T KNOW If **yes**, please fill out the chart below.	
Person with Income	**Average Number of Hours Worked per Week**	**Income from?** (work, self-employment, odd jobs, etc.)	**How often does this person get income?** (yearly, monthly, biweekly, weekly, etc.)	**How much does this person receive before taxes?**	**Does this person have an employer that offers health insurance?** If **yes**, fill out the Employer Coverage Form to find out if you can get health insurance through the NMHIX if you are found ineligible for Medicaid. You are not required to complete the Employer Coverage Form for Medicaid.
				$	❑ YES ❑ NO ❑ DON'T KNOW
				$	❑ YES ❑ NO ❑ DON'T KNOW
				$	❑ YES ❑ NO ❑ DON'T KNOW

Are any of the following deducted from your earnings?		
❑ **Alimony Paid** Who? How Much? $ How Often?	❑ **Student Loan Interest** Who? How Much? $ How Often?	❑ **Other: Type** Who? How Much? $ How Often?
❑ **Other: Type** Who? How Much? $ How Often?	❑ **Other: Type** Who? How Much? $ How Often?	❑ **Other: Type** Who? How Much? $ How Often?

7. Tell Us About Your Other Income. Examples of unearned/other income include, but are not limited to: unemployment, Social Security, pensions, retirement, rental income, capital gains, royalties, financial gifts and gambling winnings/prizes.

Person with Income	**Unearned income from?**	**How often does this person get income?** (yearly, monthly, biweekly, weekly, etc.)	**How much does this person receive?**
			$
			$
			$

Will there be changes in income?	
Do you or anyone living with you have income that changes from month to month? Examples include: loss of job, decrease in hours, change in job, change in pay, and/or working only some months of the year.	❑ YES ❑ NO ❑ DON'T KNOW If **yes**, please fill out the chart below.

Person with Income Changes	What income changes?	When and why does it change?	Total Income This Year	Total Income You Expect for Next Year
			$	$
			$	$

8. Health Care Information.	
Has anyone in the household received medical services within the last 3 months that have not been paid?	❑ YES ❑ NO If **yes**, please fill out the chart below. We may be able to help pay these bills.

Name on Bill	Bill Months

Please list all public and private health insurance, including Medicare information, for you and all people living with you who are applying for Medicaid.

Persons Covered	Insurance Company Name	Insurance Member ID # Or Medicare Claim #	Start Date

9. Managed Care Organization (MCO). This section will apply if you are found to be eligible for Medicaid. If you are eligible for Medicaid, your services will be provided by one of the four managed care organizations (MCOs) listed below. You have a choice of which MCO will provide your services. If you do not choose an MCO, you will be automatically assigned to an MCO by the New Mexico Human Services Department. Once you are enrolled with an MCO, you will have the option to switch to a different MCO within 90 days of enrollment.

Special Information for Native Americans:

If you are Native American, you are not required to choose an MCO. If you choose not to select an MCO, you will be automatically enrolled in fee-for-service (FFS) Medicaid. If you are in need of long-term care services or if you have Medicare, you will be required to choose an MCO.

I am a Native American ❑ YES ❑ NO
If **yes**, please fill out the Native American or Alaska Native section on the next page.

If **yes**, please tell us if you want to enroll in a managed care organization (MCO): ❑ YES ❑ NO
If you want to enroll in an MCO, please select an MCO below.

❑ **Blue Cross Community Centennial** (866) 689-1523 www.bcbsnm.com/community-centennial By checking this box, I wish to enroll all Medicaid recipients in my household with this MCO. **or** Only the Medicaid recipients from this household that are listed here should be enrolled with this MCO:	❑ **Molina Healthcare** (800) 580-2811 www.molinahealthcare.com By checking this box, I wish to enroll all Medicaid recipients in my household with this MCO. **or** Only the Medicaid recipients from this household that are listed here should be enrolled with this MCO:
❑ **Presbyterian Health Plan** (888) 977-2333 www.phs.org By checking this box, I wish to enroll all Medicaid recipients in my household with this MCO. **or** Only the Medicaid recipients from this household that are listed here should be enrolled with this MCO:	❑ **United Healthcare Community Plan** (877) 236-0826 www.uhccommunityplan.com By checking this box, I wish to enroll all Medicaid recipients in my household with this MCO. **or** Only the Medicaid recipients from this household that are listed here should be enrolled with this MCO:

Native American or Alaska Native. Native Americans and Alaska Natives who enroll in Medicaid, the Children's Health Insurance Program (CHIP) and the Health Insurance Exchange (NMHIX) can also get services from the Indian Health Service, tribal health programs, or urban Indian health programs. If you or your family members are Native American or Alaska Natives, you may not have to pay cost-sharing and may get special monthly enrollment periods. We are asking you to answer the following questions to make sure you and your family get the most help possible. If you need more space, please attach another sheet of paper.

Is any applicant a member of a federally recognized tribe?

❑ YES ❑ NO

If **yes**, who?

To ensure that you are not automatically enrolled in an MCO, please provide your tribal affiliation:

Is any applicant receiving per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?

❑ YES ❑ NO

If **yes**, who?

How much? $ How often?

Do any applicants ever get a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

❑ YES ❑ NO

If **yes**, who?

If **no**, is any applicant eligible to get services from the Indian Health Service, tribal health programs or urban Indian health programs, or through a referral from one of these programs?

❑ YES ❑ NO

If **yes**, who?

Is any applicant receiving payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)?

❑ YES ❑ NO

If **yes**, who?

How much? $ How often?

Is any applicant receiving money from selling things that have cultural significance?

❑ YES ❑ NO

If **yes**, who?

How much? $ How often?

10. Please Sign This Application. Your authorized representative may also sign here.

Your signature makes this application valid. This application cannot be processed unless signed. Your signature is also an indication of the following:

- I understand that making false statements or hiding information could mean state and federal penalties. I have given HSD true, correct and complete information.
- I am declaring the identity of the children under age 16 for whom I am applying.
- If asked, I will give proof of things I report to HSD. If I cannot get proof, I know that I can ask HSD to help me and I will let HSD contact other people and companies to give proof.
- I will let HSD give limited information to approved agencies that offer related assistance for which I may be eligible.
- I understand that if I receive benefits for which I am not eligible, that I may have to pay back HSD for those benefits.
- I know that HSD will check the information that I give. HSD may use computers or other ways to check the information on this form.
- I know that HSD will check the immigration status of people who apply for or get benefits. I understand that immigration status for any household member that I am applying for may be subject to verification by USCIS (INS) and that it may affect the household's eligibility and/or level of benefits.
- I understand that I must cooperate with Quality Control (QC). QC is a part of HSD. QC reviews cases to make sure we determine who can get help correctly.
- I have been given an opportunity to review my rights and responsibilities, including fair hearing rights and more.
- TRUSTS – I understand that if I, or the person(s) for whom I am applying, have set up a trust or are the beneficiaries of a trust, I must give HSD a copy of the trust document, including all attachments and related information. HSD will analyze the trust to see if it affects the Medicaid benefits for which I am applying.
- ESTATE RECOVERY – I understand that after my death, HSD can file a claim against my estate to recover the amounts that the state pays or paid on my behalf for medical assistance provided under the Medicaid program. This process is called "Estate Recovery". Estate Recovery is required by federal and state law where Medicaid recipients are 55 years of age or older and the state makes medical assistance payments on their behalf for nursing facility services, home and community-based services, and/or related hospital and prescription drug services. The amount recovered by HSD will not exceed the amount of medical assistance payments made on behalf of the Medicaid recipient. Some exclusions may apply.
- I understand that I must give HSD any money I receive for medical services that have already been paid for by Medicaid. If I fail to do so, I, or the person(s) for whom I am applying, may lose Medicaid coverage for at least one year and until the amount owed to Medicaid has been paid back in full.
- A person who is applying for or receiving Medicaid shall assign to HSD all rights against any and all individuals for medical support or payments for medical expenses paid on the applicant's or recipient's behalf and the behalf of any other person for whom application is made or assistance is received.
- I, as the Authorized Representative, affirm and agree to be legally bound to maintain the confidentiality of any information regarding the applicant or beneficiary, shall not reassign any provider claims, if applicable, and shall adhere to all requirements set forth at 42 CFR §435.923(d).
- To **withdraw** your application for medical assistance, please initial this box: ❑

Applicant's Signature	Name of Witness (only if applicant signs by mark or thumbprint)	Date
Signature of Applicant's Authorized Representative (if applicable)	Signature of Witness (only if applicant signs by mark or thumbprint)	Date

12. Register to Vote. 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 form, we will help you. The decision about whether to accept help is yours. You may fill out the application form in private. **Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.**

If you are not registered to vote where you live now, would you like to register to vote here today?	❑ YES ❑ NO

If you do not check either box, you will be considered to have decided **not** to register to vote at this time.

Signature	Date

Confidentiality: 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 to decline to register to vote, or your right to privacy in deciding whether to register or apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Office of the Secretary of State at 419 State Capitol, Santa Fe, NM 87503 or by calling 1-800-477-3632.

Program Application Information Pages

You may keep this information for your records

1.Special Needs Information

If you are a person with a disability and you require this information in an alternative format, or if you require a special accommodation to participate in any public hearing, program or services, please contact the HSD American Disabilities Act (ADA) coordinator at (505) 827-7701, through the New Mexico Relay System TDD at 1-800-659-8331, or by dialing 711. HSD requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (Revised 9/10/15)

2. Your Civil Rights / Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion and political beliefs. To file a complaint of discrimination regarding a program receiving federal financial assistance through the US Department of Health & Human Services (HHS), write to: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Ave., SW, Washington, DC 20201 or call (202) 619-0403 (voice) or 1-800-537-7697 (ITY). HHS is an equal opportunity provider and employer. (Revised 9/10/15)

3. Confidentiality

All information you give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which you have applied. Confidential information may also be released to other federal and state agencies. All information will be used to determine eligibility and/or to provide services. This information may be given to other federal and state agencies for official examination, and to law enforcement officials for the purpose of picking up persons fleeing to avoid the law. If you get benefits that you were not eligible for and have to pay them back, this is called a claim. If your household gets a claim against it, the information on this application, including all Social Security Numbers (SSNs), may be given to federal and state agencies, as well as to private claims collection agencies for claims collection action.

You only have to give US citizenship information and SSNs for household members that you are applying for. You do not need to be a US citizen to apply. Receiving medical assistance will not prevent you from becoming a lawful permanent resident or US citizen. Non-citizen immigrants who are not requesting assistance for themselves do not need to give immigration status information, SSNs or other similar proofs; however, they must give information about their income because part of their income may count toward the household's eligibility for assistance. Certain benefits may be available for people without an SSN; ask ISD. Immigration information will not be shared with any immigration enforcement agency.

HSD will check with other agencies, the federal Income and Eligibility Verification Service (IEVS) and the Public Assistance Reporting Information System (PARIS) to verify the information you give us. This information may affect your household eligibility and benefit amount. (Revised 9/10/15)

4. Child Support Enforcement Division

By accepting medical assistance, you give HSD rights to collect child support from your child or children's absent parent(s). You must help HSD find the absent parent(s) unless there is a good reason not to do so, such as domestic violence; ask a caseworker. If it is decided that you have to work with the Child Support Enforcement Division (CSED) to establish or enforce child support and you do not, the adults in the household may lose their medical assistance. (Revised 9/1015)

5. Interview

The medical assistance programs that you can apply for with this application do **not** require an interview.

6. Proof Information

HSD will check electronic data sources to see if it can verify your income and other information you provided on this application without requiring paper documentation. If HSD cannot verify your income and other information through electronic data sources, then HSD will ask you to provide proof of the information you provided on your application. You will receive a letter in the mail asking you for this information. If you need more time to provide proof to HSD, you may ask for more time by contacting ISD.

See the list on the next page of what information HSD may verify and examples of proof that you may be asked to provide.

Verification of:	Examples of Proof you May be Asked to Give HSD
Where you live	Utility bill, rental agreement, letter addressed to you at the address you gave on your application
Social Security Number (SSN)	Social Security card or letter from the Social Security Administration (SSA) with your name and SSN
Identity, Relationship and Age	Driver's license, Social Security card, birth or baptism certificate(s), citizenship/naturalization records, Indian census records, Certificate of Indian Blood (CIB), government records, court records, voter registration card, divorce papers, US passport, school or day care records, insurance policies, church records or family bible, letter from a doctor, religious or school official, or someone who knows you, the child/children's relationship with you and knows the child's date of birth.
US Citizenship	For medical assistance, the federal government requires that individuals may have to give certain original documents or certified copies that verify citizenship. Any original documents will be copied and returned.
Immigration Status	If you are an immigrant applying for medical assistance, you may have to provide original USCIS (formerly the INS) records or certified original copies.
Disability	Medical records that say how long you will be disabled, whether or not you can work and if constant help/care is needed.
Pregnancy	You do not need to provide documents to verify your pregnancy.
School Attendance	You do not need to provide documents to verify school attendance.
College Student	You do not need to provide documents to verify college attendance.
Student Financial Aid	You may be asked to provide a letter from the financial aid office stating what types and amounts of financial aid and the costs you will have to pay for your schooling.
Income – The most recent 30-day period or all from last month	**Earned income:** Check stubs or a letter from your employer with the hours you will work and the pay you will get. If you are self-employed, you may be asked for income tax records, business records or personal wage records. **Unearned income:** Copies of checks received or a letter from Social Security, Unemployment Compensation, Worker's Compensation, Veteran's Administration, Bureau of Indian Affairs, Public Employees Retirement, etc. Alternative verification may be accepted; please talk to your caseworker.
Loss of a Job – The past 60 days	Letter from the employer
Health Insurance	ID card or letter from your insurance company
Medicare Part A	ID card or letter from the Social Security Administration

7. Non-Citizen Immigrant Eligibility

Many immigrants can get Medicaid residing in New Mexico. Some immigrants must have been in a certain status for 5 years before they can get Medicaid. There are many exceptions. Any lawfully residing child under the age of 21 or pregnant woman that meets all other requirements can get Medicaid right away. So can refugees, asylees, battered spouses and children, and many others. Some immigrants are eligible without a social security number. Even if you do not have an immigration status that qualifies you for Medicaid, you may be able to get Medicaid for emergencies. Ask a caseworker for more information. We keep your information private and only share information with other government agencies to see which programs you qualify for. Immigrants in one of the following statuses may be eligible for Medicaid if they meet other program requirements:

1 – Lawful Permanent Resident (LPR)	9 – Victim of trafficking and his/her spouse, child, sibling or parent	17 – Applicant for adjustment to LPR status, with approved visa petition
2 – Lawful Temporary Resident (LTR)	10 – Individual with non-immigrant status (includes worker/student visa, and citizens of Micronesia, the Marshall Islands and Palau)	18 – Applicant for asylum
3 - Asylee	11 – Temporary Protected Status or applicant for Temporary Protected Status	19 – Registry applicant with Employment Authorization Document (EAD)
4 – Refugee	12 – Deferred Enforced Departure	20 – Order of Supervision (with EAD)
5 – Cuban/Haitian entrant	13 – Deferred Action Status	21 – Applicant for cancellation of removal or suspension of deportation (with EAD)
6 – Paroled into the US	14 – Granted withholding of deportation or withholding of removal	22 – Other/Unsure
7 – Conditional entrant granted before 1980	15 – Applicant for withholding of deportation or withholding of removal	
8 – Battered spouse, parent or child	16 – Applicant for special immigrant juvenile status	

8. Fair Hearing Rights

You can ask for a hearing if you do not agree with a decision HSD has made regarding your application/benefits. A hearing will give you a chance to explain why you do not agree. Any time you disagree with a decision taken on your case, you have the right to request a fair hearing with an official who is required by law to review the facts of every case in a fair and objective manner and give you a chance to explain why you do not agree.

You can ask for a fair hearing when you apply for benefits and are denied; you disagree with a decision on your case; you believe your benefits were not determined correctly; or a change was made that you do not agree with.

You have 90 days from the date of notice to ask for a fair hearing. If you ask for a hearing within 13 days from the date of the notice, you will continue to get the same amount of benefits you received before we took the action in the notice. You will continue to get these benefits until HSD decides your case, unless another change is made in your case. Changes in benefits may be made after you have asked for a hearing if the reason for the change is not the same as the reason for the hearing. If you lose the hearing, you may have to pay back any benefits you received while HSD decided your case. You do not have a right to a fair hearing if HSD's decision that you are challenging was the result of a federal or state mass change.

You can ask for a fair hearing the following ways:

- Complete and return the bottom of a notice, or
- Write or call your local ISD office or the Customer Service Center at 1-800-283-4465, or
- Write to the HSD Fair Hearings Bureau at PO Box 2348, Santa Fe, NM 87504-2348, or
- Call the HSD Fair Hearings Bureau at (505) 476-6213.

If you disagree with a decision by the New Mexico Health Insurance Exchange (NMHIX), you may appeal the action by contacting the NMHIX at 1-800-318-2596 and inform the NMHIX that you believe their action should be reconsidered. You may authorize someone else to represent you in the appeals process.

After you ask for a fair hearing, HSD or the NMHIX will send you a letter telling you the date, time and place where your hearing will be held. HSD hearings are usually at the ISD office. The hearing will be conducted by a hearing officer from the HSD Fair Hearings Bureau or the NMHIX. Prior to the hearing, you or your representative can look at your case record and any proof that will be used to decide your case. You will tell why you believe the HSD or NMHIX decision to be wrong. You may bring witnesses and present proof. You may question the county office or the NMHIX about the action taken and the proof presented. You may represent yourself or you may be represented by a friend, household member or an attorney. For information on where you can get free legal help, call 1-800-340-9771.

After the hearing, the hearing officer will make a report. The HSD Division Director or the NMHIX Director will decide whether the action was right or wrong. After your case has been decided, you will be sent a letter telling you about the decision and why the decision was made. (Revised 9/10/15)

Employer Coverage Form

If you are applying for help with health insurance costs from the NM Health Insurance Exchange (NMHIX), please complete this form.
Failure to complete this form will <u>not</u> delay your application for other benefits like food assistance, cash assistance or Medicaid.

The New Mexico Health Insurance Exchange (NMHIX) application asks questions about any health coverage available through a current job (even if it's from another person's job, like a parent or spouse) to figure out if you might be able to get help paying for health insurance. Use this form to get the information you need from the employer who offers health coverage. We'll verify this information, so it's important to be accurate. If you have more than one job that offers health coverage, use a separate form for each employer. Use this completed form when you fill out a NMHIX application.

Employee Information

The employee needs to fill out this section. Write down the employee's information, then you may request the employer information below from the employer.

Employee Name (First, Middle, Last)	Social Security Number

Employer Information:

Ask the employer for this information.

Employer name	Employer Identification Number (EIN)	
Employer Address	Employer Phone Number ( ) –	
City	State	Zip Code

Who can we contact about employee health coverage at this job?

Name:_____ Phone:_____ Email:_____

Tell us about the health plan offered by this employer

❑ This employee isn't eligible for coverage under this employer's plan.

❑ This employee is eligible for coverage under this employer's plan on_____ (Start Date).

What is the name of the lowest cost self-only health plan this employee could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.) Name:_____

❑ No plans meet the "minimum value standard"

How much would the employee have to pay in premiums for that plan?

$_____ How Often? ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly ❑ Other_____

Register to Vote

Protected: See Privacy Notice*

PERSONAL INFORMATION

This information not to be copied.

1	NAME: Last	First	Middle Name or Initial	Gender	Birth Date	Social Security Number

PHYSICAL STREET ADDRESS WHERE YOU LIVE NOW

2	Street Address	Apartment, Unit, or Lot #	City	Zip

ADDRESS WHERE YOU GET YOUR MAIL (If different from above)

3	Address	City	Zip

4	If you are changing your name on this application, under what full name were you previously registered? Last Name - First Name – Middle Name or Initial	5	E-Mail Address (*optional)

POLITICAL PARTY

6	▸ NOTE:You must name a major political party to vote in primary elections	Party	If you choose NO PARTY, check this box. ☐

DAYTIME TELEPHONE NUMBER (optional)

7	May the County Clerk make this telephone number public for election purposes? ☐ YES ☐ NO

POLL WORKER

Would you like to serve as an election day precinct worker? ☐ YES

8	I hereby authorize you to cancel my previous registration in the following county and state.	City or Township	County	State

Please answer the following questions:

9

Are you a citizen of the United States? ☐ YES ☐ NO

Will you be 18 years of age on or before the next general election? ☐ YES ☐ NO

If you checked "NO" to any of the questions above, do not complete this form.

If you have been convicted of a felony and are currently on parole or supervised probation do not complete this form

TODAY'S DATE

➡ Month Day Year

_____/_____/_____

10	Name of agent who assisted you in filling out this form:	VRA ID #

ATTESTATION OF QUALIFICATION

I swear/affirm that I am a citizen of the United States and a resident of the state of New Mexico; that I have not been denied the right to vote by a court of law by reason of mental incapacity; that I am, or will be at the time of next election, 18 years of age; and, if I have been convicted of a felony, I have completed all conditions of parole and supervised probation, served the entirety of a sentence or have been granted a pardon by the governor. I further swear/affirm that I am authorizing cancellation of any prior registration to vote in the jurisdiction of my prior residence; and that all information I have provided is correct.

➡ SIGN YOUR FULL NAME OR MARK ON THE LINE BELOW:

DO NOT WRITE IN SHADED AREAS – FOR OFFICIAL USE ONLY

Accepted for filing in County Registration Records	PCT.	MUN.	PRC DIST.	REP DIST.	SEN. DIST	SCHOOL	C.C.
_____/_____/_____ Date County Clerk _____/_____ Filing Clerk							

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IN ORDER TO PROCESS YOUR CERTIFICATE OF REGISTRATION YOU MUST COMPLETE THIS APPLICATION.

YOU WILL RECEIVE CONFIRMATION BY MAIL OF YOUR REGISTRATION FROM THE COUNTY CLERK.

*PRIVACY NOTICE

Your Social Security number and date of birth are required to register to vote. Pursuant to New Mexico law, the secretary of state, county clerk or any other registration official agent may not release to the public a voter's social security number or date of birth. A person who unlawfully copies, conveys, or uses information from a certificate of registration is guilty of a fourth degree felony. See NMSA, 1978 § 1-4-5 and NMSA, 1978, 1-4-5.4.

Per NMSA 1978 § 1-5-14(D) voter files provided to the publish shall not include email address.

USE THIS AREA ONLY IF YOU LIVE AT A RESIDENCE WITH NO PHYSICAL ADDRESS

If the address where you live ("Physical Address") is one of the following:

- a rural address
- a non-street address
- a non-traditional place

In the space provided to the right, you must draw a map of where you live in relation to local landmarks, such as roads, schools, churches, stores, etc.
This will help your county clerk to determine your correct voting precinct.

Also, in the space below "RURAL ADDRESS DESCRIPTION", please describe the following:

1. the actual number of the state or county road on which your residence is located, and on which side of the road it sits (east, west, north, south);
2. the number of the nearest state roads that cross your road (in both directions from either side of your home), or the names of the identifiable landmarks;
3. the distance and direction you would travel from home to reach these roads;
4. the distance you would travel to reach your home if you live on a private road that is an extension of a public road (please note at which end of the public road your road begins east, west, north or south.
   EXAMPLE RD 678, north side, 1 mile east of RD 615
   -OR-
   RD 73, west side, 1 mile north of Smith's store and 4 miles south of RD 698
5. any county issued rural address assigned to your physical residence where you live now:
   EXAMPLE 3251 CR W Grady, NM 88120
   This address may also be used in Block 2 "PHYSICAL ADDRESS WHERE YOU LIVE NOW" on the reverse of this form.

MAP

N
W + E
S

RURAL ADDRESS DESCRIPTION

ALL VOTER REGISTRATION FORMS MUST INCLUDE A MAILING ADDRESS IN BOX 2 OR BOX 3 ON THE REVERSE OF THIS FORM.