OTERO COUNTY
HEALTHCARE SERVICES

HEALTHCARE ASSISTANCE PROGRAM
(HCAP)
Serving the Residents of Otero County

Office Hours
Monday - Friday
8:00am – 5pm

Schedule may vary. Please call for appointment.

1101 New York Avenue
Alamogordo, NM 88310
575-434-4902

***IMPORTANT NOTE* -** Your application for assistance will not be considered unless you have applied for Medicaid. The letter of acceptance or denial must be provided.

Purpose
Access to health care reduces long term medical and social costs. An effective health care system must retain local health care efforts, stimulate local innovations for meeting particular health needs, and use existing resources to expand health care options, especially for those citizens unable to pay for their own care. Each individual county in the state of New Mexico is responsible for ambulance transportation, hospital care, or the provision of health care to indigent patients domiciled in the respective county, as determined by resolution of the board of county commissioners, in addition to providing support for the state's Medicaid program. (NMSA 1978 §27-5-2A).

Pursuant to NMSA 1978 §27-5-6E, the Otero County Health Care Assistance Fund must comply with the standards of the Health Insurance Portability and Accountability Act (HIPPA).

The Healthcare Service program previously known as Indigent Fund is the payer of "last resort" and is a claims-based program. A patient must have received services from one of our contracted providers.

Pursuant to NMSA 1978 §27-5-6G, the Otero County Health Care Services Department has contracted with the following providers for services for qualified patients domiciled within Otero County:

*Gerald Champion regional Medical Center (GCRMC)
Presbyterian Hospital, Albuquerque, NM
Presbyterian Medical Services, Tularosa, NM
Presbyterian Medical Services, Alamogordo, NM
Presbyterian Medical Services, Chaparral, NM
Sacramento Mountain Medical, Cloudcroft, NM
Memorial Medical Center, Las Cruces, NM

*Prior to application for assistance from Otero Healthcare Services please go to GCRMC's website to download their Assistance Application form. GCRMC is the county's Safety Net Care Pool Provider. Pursuant to NMSA §27-5-11(B), GCRMC must provide financial assistance.
Please visit: http://www.gcrmc.org/News/CharityCare

At this time we are not contracted with any out of State providers.

Discount Dental Plan:
Otero County offers help with a Discount Dental Plan. Just visit the website www.mycountydental.com/otero, or call 1-877-354-6226 to sign up and locate a participating provider.

Discount Prescription Drug Cards:
To get help with the high cost of prescriptions, Otero County and the National Association of Counties can provided Prescription Discount Cards either by visiting the following website, www.caremark.com/naco, or by calling 1-877-321-2652. Cards can be picked up at the Otero County Health Office.

Clinics:
Primary preventive care is generally covered at the clinic site and bills should be at least $50.00 to apply for assistance. If qualified under residency and income guideline you may be eligible for one year's approval status for assistance.

Hospital Services:
Services such as emergency room visits, inpatient services, and out-patient services require an application or recertification depending on status of the itemized bill from the hospital. Bill must be greater than $350.00 if the hospital services do not occur at GCRMC.

Diagnostic Tests:
All diagnostic tests done at the hospital are covered as long as they are part of the itemized bill from the contracted hospital.

Ambulance bills:
Ambulance bills from **American Medical Response** (**AMR**) are covered but you need to request assistance. We do not automatically file a claim for you. It is not part of the hospital bills. /

Program will pay:
Claimants must be a resident of Otero County 90 days prior to treatment. Once a claimant has qualified, they are approved for $30,000 per fiscal year in combined medical providers, and have a maximum of $10,000 per claim. Once the $30,000 has been exhausted claims will be denied until next fiscal year.

Program will not pay:
Elective surgery or procedures
Private Physician Services in office
Private Physician contracted with GCRMC (unless billed directly through GCRMC)
No Physician payments after insurance

Please do not hesitate to apply for assistance. We will look at each individual and unique circumstance to assist in any way the Otero County Healthcare Services Department can as allowed by State Statute and County Ordinance.

Time Limits for filling:
You have 75 days from the date of discharge or once a bill has occurred with any of the contracted medical providers to file for assistance. You have 30 days to provide any and all paper work required and requested. Time **may** be extended upon request and approval for up to one year for paper work needed to complete the process of your claim(s).

Income Limits:
Income limits change annually as the State of New Mexico per capita income is adjusted per NMSA §27-5-4G. To remain in compliance, Otero County Healthcare Services uses the Federal Poverty Limits (FPL) as is a guideline for income limits.

Income Amount – 300% FPL	Household total
$36,420	Household of 1
$49,380	Household of 2
$62,340	Household of 3
$75,300	Household of 4
$88,260	Household of 5
$101,220	Household of 6

Resource Limits:
Assets are not to exceed $20,000. Applicant's owned primary residence and lot is not considered in the assets calculation.

Civil Rights:
All programs administered by the Otero County Healthcare Services are equal opportunity programs. If you believe you have been treated unfairly because of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public assistance program, you may file a complaint. Complaints of discrimination may be filed with the County Manager located in the Otero County Building 1101 New York Ave, Alamogordo, NM 88310.

In accordance with Federal Law, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

If your application has been denied in whole or in part, or county assistance from the fund is denied, modified, or terminated, a written request for a hearing must be sent to the Claims Administrator within thirty (30) days of fund denial, or fund assistance modification, or fund assistance termination. Failure to timely submit a written request for hearing shall result in the denial, modification, or termination being deemed final. The Claims Administrator shall schedule the appeal for reconsideration by the Health Care Board. If the applicant remains dissatisfied with Board action on reconsideration, the applicant shall request a second hearing, in writing, within 15 days of the meeting at which the matter was reconsidered. The Administrator shall schedule a hearing before a hearing officer within 30 days. The hearing shall be conducted by a hearing officer appointed by the County Administrator. Within five days of the hearing, the hearing officer shall render a written decision, by findings of jurisdiction and facts. (§140-15(A)-(E))

Privacy:
The information you give Otero County Healthcare Services will be used to determine whether your household is eligible or continues to be eligible to take part in the Otero Healthcare Fund program. We will check this information through computer matching programs or other means. This information will also be used to make sure that you meet program rules and help us to manage the program. 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, may be given to Federal and State agencies, as well as private claims collection agencies for claims collection action.

Providing the requested information, including Social Security Numbers of each household member is voluntary. However, each person applying for assistance must give a Social Security Number or it will result in the denial of program benefits to each individual applicant failing to give a Social Security Number. Any Social Security Numbers given will be used and disclosed in the same manner as Social Security Numbers of eligible household members.

Otero County Healthcare Assistance Application Instructions

APPLICATION INSTRUCTIONS:

1. **Please answer all questions.** List all persons living within the same household, whether or not they are dependents.

2. Before submitting the application, please read and sign the Verified Statement. Pursuant to NMSA §27-5-12(3), the Verified Statement of Qualification must be included in the application file. The statement shall constitute an oath of the person signing it, and any false statement in the statement made knowingly constitute a felony. These statements shall be made open to the public pursuant to NMSA §27-5-7(C). Refusal to sign the Verified Statement of Qualifications will result in automatic denial of assistance.

3. Please prepare to gather the necessary documentation for verification of eligibility. Examples are listed below for clarification. You should be ready to give as many facts as you can. If there are unresolved questions about your eligibility, you will be asked to give proof. A Healthcare Review Specialist will give you a list of everything you still need to give, along with a receipt for proof you provided. If you need help, ask a Healthcare Review Specialist.

<table>
<tr><th colspan="3">Examples of Proof</th></tr>
<tr><td>Residency</td><td colspan="2">Driver License or State Issued Identification Card (if reflects current residing address), Utility bills, Rent agreement, Property taxes, and/or current voter registration.
Must provide a 90 day reflection of Residency in Otero County.</td></tr>
<tr><td>Social Security Number</td><td colspan="2">Social Security card or letter from the Social Security Administration (SSA) with your name & number</td></tr>
<tr><td>Identity</td><td colspan="2">You may give any one of these: Driver’s License, State Issued Identification card, U.S. Passport. If you are reasonably unable to provide these documents, ask the Healthcare Services staff for alternatives.</td></tr>
<tr><td rowspan="2">U.S. Citizen</td><td colspan="2">U.S. Citizenship is required. For medical assistance, Otero County requires that all individuals give certain ORIGINAL documents (not copies) that verify Citizenship, Identity, or proof of Legal Permanent Status. Original documents will be copied and returned.</td></tr>
<tr><td>Proof of Citizenship and ID together
A Passport
A certificate of naturalization (Form 550 or N-570)
A certificate of U.S. Citizenship (N-560 or N-561)
A certificate of Indian Blood (CIB)</td><td>Proof of Citizenship Alone
U.S. birth certificate
If you were born in New Mexico, you may obtain your birth certificate from the New Mexico Department of Health Vital Records.
https://nmhealth.org/</td></tr>
<tr><td>Income</td><td colspan="2">Earned Income: Check-stubs, a letter from the employer with the hours you will work and the pay you will get. If you are self employed, you may provide a copy of your income tax forms, business records or personal wage records.
Unearned Income: Copies of your check, or a letter from Social Security, Unemployment Compensation, Worker’s Compensation, Veterans Administration, Bureau of Indian Affairs, Public Employees Retirement, IRAs, Student Loans, Scholarships, etc.

<u>Required:</u>
Earned and Unearned income must reflect the most recent three paychecks or paystubs.
Last year’s Federal and State tax returns with all W-2s. If you did not file a return contact the Review Specialist for further instructions.</td></tr>
<tr><td>Resources/Assets/Debts:</td><td colspan="2">Checking/Savings account statements, other investments such as stocks, bonds, CDs, escrow accounts, settlements, inheritance, divorce petitions and/or decrees, etc.

This information must reflect the most recent three paychecks or payroll stubs.
Applicant are allowed assets not to exceed $20,000</td></tr>
<tr><td>Health Insurance</td><td colspan="2">ID card or letter from your insurance company
Acceptance or Denial letter from Medicaid.
**All applicants are required to apply for Medicaid Assistance. **</td></tr>
<tr><td>Medicare Part A</td><td colspan="2">Insurance card or letter from Social Security Administration</td></tr>
<tr><td>Medical Bills</td><td colspan="2">Any and all Medical Invoices incurred from the past 75 days in which you are applying for payment assistance.</td></tr>
</table>

Failure to provide any of the necessary documents will result in the denial of your application
(Any information that is provided to determine eligibility will be held confidential, except as required by law.)

HEALTHCARE REVIEW SERVICES

Otero County Healthcare Assistance Application

OTERO COUNTY, NEW MEXICO

Office Use Only Client Number:	Status: ☐Application ☐Redetermination	Former Recipient: ☐Yes ☐No	Application Date:	Log Date:

PATIENT/CLAIMANT INFORMATION

If you need help filing in this application or obtaining information, please contact the Otero County Healthcare Services Dept. If you are applying for someone else, complete each section for that person.
Proof of Identity is required.

Legal Name (Last, First Middle):	Date of Birth:	Social Security Number:	Telephone Number:

Street Address	City	County	State	Zip

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

Street Address or P.O. Box	City	County	State	Zip

Please list any physical address(es) you resided at within the past 90 days.

Street Address	City	County	State	Zip
Street Address	City	County	State	Zip

Email Address:	Do you prefer email correspondence? ☐Yes ☐No

Authorized Representative of Guardian

The authorized representative may or may not be the same individual designated as an authorized representative for the application processing or for meeting reporting requirements. The authorized representative designation must be made in writing.

Do you want this person to: (check all the apply)

☐Apply for benefits upon your behalf?

☐Receive correspondence from the Otero County Healthcare Office?

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

RESIDENCY

Proof of residency is required.

Have you been a resident of Otero County for a minimum of ninety (90) days?	☐Yes	☐No	☐N/A
Are you homeless?	☐Yes	☐No	☐N/A

List everyone that lives in your household. You only have to give U.S. Citizenship and Social Security Numbers for those household members that you are applying for assistance.

Name (First and Last)	Relationship	Gender M/F	Date of Birth	Race/ Ethnicity (optional)	SSN# (optional for non-applicants)	U.S. Citizen Y/N	Legal Immigrant Status? Y/N	Will you file federal income taxes for the current year? Y/N	Will you claim this person on your current year's tax return? Y/N
1.	(Self)								
2.									
3.									
4.									

Racial and ethnic data on participating households is voluntary, it will not affect the eligibility or the amount of benefits your household will receive. Native Americans are urged to identify themselves as such because Native Americans are entitled to certain special protections under the law. The reason we ask everyone for racial and ethnic information is to assure that benefits are distributed without regard to race, color, or national origin.

You have the right to file your application today, please do not delay. You can bring, mail or fax the application to the Otero County Healthcare office.

► **Sign Here** _____ **Today's Date**_____

Please Answer the Following Questions About the People You Listed who are seeking eligibility with Otero County's Healthcare Assistance Program.

List all individuals applying for assistance who have legal immigrant status and add information below.

	Who?	Document Type:	Id Number:
	Who?	Document Type:	Id Number:
	Who?	Document Type:	Id Number:

Income:

Note: If you are offered health insurance from any employer please fill out the Employer Coverage form attached to this application.
Previous year's tax documents may be required for verification of yearly income.
Most recent three (3) paychecks or payroll stubs is required.

Have you or has anyone living with you received earned income or expect to receive income this month? ☐Yes ☐No ☐Don't Know
If yes, please complete the chart below.

Person with Income	Average number of hours worked?	Income From? (Work, self-employment, odd jobs, food stamps, VA Benefits, SSI, Workman's Comp., etc.)	How often Received? Yearly, Monthly, Biweekly, Weekly,	**How much is received?**	**Does this employer offer Health Insurance? (Y/N)** If yes, fill out the employer coverage form.

Additional Income:

Examples of unearned income include, but are not limited to: Unemployment, Social Security, pensions, retirement, rental income, veteran's payments, child support, Indian monies, capital gains, dividends/interest, and per capita payments.

Person with Income	Unearned Income From?	How Often Received? (Yearly, Monthly, Biweekly, Weekly, etc.)	How much do they receive?
			$
			$
			$
			$

Assets/Resources

Certain resources/assets such as bank accounts may count toward your eligibility. Certain resources/assets may not count, such as a home and lot where you live and the resources of people who receive Supplemental Security Income (SSI).

Check all of the items that apply to you and all people living with you:

☐Cash on Hand	☐Checking Account	☐Livestock	☐CD – Certificate of Deposit
☐Stocks or Bonds	☐Retirement Account	☐Recreation Vehicles	☐House/Land – Not Occupying
☐Savings Account	☐Trust(s)	☐Other: -	

Describe all of the items from above that are owned by you and all the people living with you:

Item	Who Owns Them?	$Value?	Bank or Company Name?
		$	
		$	
		$	
		$	
		$	
		$	
		$	

Health Care Information:

Please note that all applicants MUST apply for Medicare/Medicaid prior to approval of assistance from Otero County Healthcare Services. The letter of Medicare/Medicaid denial is required to be provided. Partial Medicaid coverage is considered a denial letter by the Otero County Healthcare Services.

Have you or anyone in your household sought Medicaid or Medicare eligibility?	☐Yes	☐No
Was your Medicaid/Medicare eligibility denied or accepted? Please provide a copy of the denial/acceptance letter.	☐Accepted	☐Denied
Has anyone in the household received medical services within the last 75 days that have not been paid?	☐Yes	☐No
Does anyone in your household have health insurance? If Yes, please list all health insurance including Medicare/Medicaid information for you and all people applying for assistance.	☐Yes	☐No

Persons Covered	Insurance Company Name	Medicare/Medicaid Claim Number or Insurance Member ID Number	Start Date

Healthcare Billings: List all bills and totals that have occurred within 75 days. Proof of bill is required.						
Hospital/Clinic/Other Provider	Hospital/Clinic Account Number	Type of service(s)	Date of Service	Date of Discharge	Amount Paid by other source	Bill Total
Totals						

Your Signature (Your authorized representative may also sign here)

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

- I understand that making false statements or hiding information could mean penalties and I have given Otero County Healthcare Services true, correct, and complete information.
- I am declaring the identity of the children under age 16 for whom I am applying.
- I will give proof of things I report to Otero County Healthcare Services. If I cannot get proof, I know that I can ask Otero County Healthcare Services to help me. Additionally, I hereby give permission to Otero County Healthcare Services to contact other people and companies to obtain proof of statements I have made in my application.
- I hereby give permission to any providers treating me to release my medical records to the Otero County Healthcare Services Department for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment by the Otero County Healthcare Assistance Program.
- I understand that as part of the provision of Healthcare Services, Otero County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and/or any plans for future care or treatment.
- I will let Otero County Healthcare Services give limited information to approved agencies which give other related help 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 Otero County Healthcare Services back for those benefits.
- I know that Otero County Healthcare Services will check the information that I give. Otero County Healthcare Services may use computers and/or any other means to check the information on this form. Otero County may also use third party sources to verify eligibility information.
- I understand that I must cooperate with the Healthcare Review Specialist (HRS). HRS reviews cases to make sure we determine who can get help correctly.
- 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 Otero County Healthcare Services a copy of the trust document, including all attachments and related information. Otero County Healthcare Services will analyze the trust to see if it affects the benefits for which I am applying.
- I understand that I must reimburse Otero County Healthcare Services any money I receive for medical services resulting from any cause of action. If I fail to do so, I, or the person(s) for whom I am applying, may lose eligibility coverage for at least one year AND until the amount owed to Otero County Healthcare Services has been paid back in full.

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

Employer Coverage Form
If you are unemployed or retired, you do not need to fill out this section.

Employee Information

The employee needs to fill out this section. Write down the employee's information then you may request the information below from the employer. Use this completed form when you fill out an application for assistance from the Otero Health Care Assistance Fund.

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 is not eligible for coverage under this employer's plan.

☐The employee is eligible for coverage under this employer's plan.	(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 values 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 -

Verified Statement of Qualification and Release of Information
Otero County Health Care Review
Pursuant to §24-5-12

I attest that I am unable to pay the cost of the care administered, all assets owned are listed, and there is no insurance to cover my medical bills, other than what was stated on this application.

I authorize the contracted Provider(s) and Health Care Review Specialist(s) to make any inquiry of any person, firm, or corporation for financial, residential, and medical information as may be requested. I further agree to save and hold harmless any person, firm, or corporation, including any financial institution or agency from any liability whatsoever for the release of information relevant to this statement and the investigation of the facts pertinent to this claim.

I, the patient, and/or the person applying on behalf, declare the above to be true and correct under penalty that any false statements made knowingly shall constitute a felony.

Print Name	Signature	Date
Print Name	Signature	Date