Healthcare Assistance Program (HCAP)
Application Instructions
OTERO COUNTY, NEW MEXICO

1101 New York Avenue
Alamogordo, NM 88310
Phone: 575-434-4902
Fax: 575-434-2888

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 1978 §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 1978 §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 or clarification. A Department staff member 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 Department staff member.

Examples of Proof	
Residency	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**.
Social Security Number	Social Security card or letter from the Social Security Administration (SSA) with your name & number
Identity	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.
U.S. Citizen	U.S. Citizenship is not required. For medical assistance, Otero County requires that all individuals give certain ORIGINAL documents (not copies) that verify identity. Original documents will be copied and returned.
Income	**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. **Required:** 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 Department for further instructions.
Resources/Assets/Debts:	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. Applicants are allowed assets not to exceed $20,000
Health Insurance	ID card or letter from your insurance company Acceptance or Denial letter from Medicaid. ****All applicants are required to apply for Medicaid Assistance. ****
Medicare Part A	Insurance card or letter from Social Security Administration
Medical Bills	Any and all Medical Invoices incurred from the past 75 days in which you are applying for payment assistance.

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.)

Civil Rights:
All programs administered by the Otero County Healthcare Services Department 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 Office of the Otero County Attorney 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, 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 Otero County Board of County Commissioners or 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.

An Appeal Form is available on the Otero County website, www.co.otero.nm.us.

Privacy:
The information you give Otero County Healthcare Services Department will be used to determine whether your household is eligible or continues to be eligible to take part in the Healthcare Assistance Program (HCAP). 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 you may have to pay them back. If your household must reimburse the county, 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 collection action.

Providing the requested information, including Social Security Numbers (SSN) or an Individual Taxpayer Identification Number (ITIN), of each household member is voluntary. However, each person applying for assistance must give a SSN or ITIN or it will result in the denial of program benefits to each individual applicant failing to give an SSN or ITIN.

A complete **Privacy Practice Notice,** as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA), is available on the Otero County website, www.co.otero.nm.us. Upon your request, we will provide you with the most current Privacy Practices Notice by either mailing the Notice to an address you provide or by delivering a Notice to you at our office. Please review it carefully as it describes how we may use and disclose information about you and your ability to access information about you.

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APPLICANT 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.

1. Full Legal Name:				
2. Sex: ☐Male ☐Female	3. Date of Birth:	4. Social Security Number or ITIN:	5. Telephone Number:	☐Mobile ☐Home
6. Email Address (*optional*):				

RESIDENCY
Proof of 90-day residency is required.

7. Physical Street Address	City	State	Zip Code

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

8. Mailing Street Address or P.O. Box	City	State	Zip Code

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

9. Physical Street Address of past 90 days	City	State	Zip Code	Date Range of Residence (mm/dd/yyyy - mm/dd/yyyy)
1)				
2)				

AUTHORIZED REPRESENTATIVE OR GUARDIAN
The authorized representative can be a person who helped you apply for and 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. At any time, you may rescind an Authorized Representative's authorization to act on your behalf.

10. Which of the following do you give an authorized representative permission? (choose all that apply)
☐Apply for benefits upon my behalf
☐Receive correspondence from the Otero County Healthcare Services Department

11. Name of Authorized Representative			12. Date of Birth (mm/dd/yyyy)	
13. Organization Name (If applicable)			14. Telephone Number	
15. Physical Street Address	Mailing Address	City	State	Zip

To change or remove your authorized representative, or for more information, contact the OCHSD at 1-575-434-4902. Our hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m.

HOUSEHOLD MEMBERS TABLE
List everyone that lives in your household. You do not need to list yourself. Only provide Social Security Numbers for those household members applying for assistance.
All supporting documents to verify identity, income, residency, and assets will need to be provided for each additional household member.

ADDITIONAL HOUSEHOLD MEMEBRS LIST					This section is only required for each person applying for assistance.
16. A. Full Name	B. Relationship	C. Sex M/F	D. Date of Birth	E. Will you claim this person on your current year's tax return? Y/N	F. SSN/ITIN
1)					
2)					
3)					
4)					

INCOME TABLE:
List all sources of income: earned and unearned.
Examples of income include, but are not limited to: any employment or self-employment earnings**,** Unemployment, Food Stamps, Workman's Comp., Social Security, pensions, retirement, rental income, Veteran's payments, child support, Indian monies, capital gains, dividends/interest, and per capita payments.
Most recent three (3) paychecks or payroll stubs are required.
Previous year's tax documents are required for verification of yearly income.

17. A. Person with income	B. Income Source? (Work, self-employment, odd jobs, food stamps, VA Benefits, SSI, Workman's Comp., etc.)	C. How often received? (Yearly, Monthly, Biweekly, Weekly, Irregular)	D. How much is received?	E. Does this employer offer Health Insurance? (Y/N)
1)			$	
2)			$	
3)			$	
4)			$	

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).

18. Check all of the items that apply to you and all household members:

☐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) ☐Vehicle ☐ Other -

19. Assets/Resources Table - Describe all of the items from above that are owned by you and all the people living with you:

A. Item	B. Who Owns Them?	C. $Value?	D. Bank or Company Name?
1)		$	
2)		$	
3)		$	
4)		$	

MEDICAL INSURANCE AND LIABILITY
Please note that all applicants MUST apply for Medicaid. The letter of Medicaid denial is required to be provided. Partial Medicaid coverage is considered a denial. If you answer 'yes' to questions 21-26, proof may be required.

20. Have you or anyone in your household sought Medicaid eligibility?	☐Yes	☐No
21. Did you receive medical treatment as a result of motor vehicle accident or crime? Provide police report and auto insurance information, if yes.	☐Yes	☐No
22. Are there any liability claims or legal actions pending?	☐Yes	☐No
23. Do your or anyone in your household have health insurance or any other medical resource? If Yes, please list all health insurance including Medicare/Medicaid information for you and all people applying for assistance.	☐Yes	☐No

Health Insurance Table

24. A. Persons Covered	B. Insurance Company Name	C. Medicare/Medicaid Claim Number or Insurance Member ID Number	D. Start Date
1)			
2)			
3)			
4)			

Healthcare Billings:
List all bills and totals that have occurred within 75 days. Proof of bill is required.

25. A. Hospital/Clinic/Other Provider	B. Hospital/Clinic Account Number	C. Date of Service	D. Date of Discharge	E. Amount Paid by other sources	F. Bill Total
1)					
2)					
3)					
4)					
Totals				G.	H.

Verified Statement of Qualification and Consent to Obtain and Release of Information
Healthcare Service Department, Otero County
Pursuant to NMSA 1978 §24-5-12

Your signature makes the Healthcare Assistance Program (HCAP) Application valid and cannot be processed unless signed.
Your signature is also an affirmation and agreement to the following:

- **Declaration of Indigence**
  - 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.
- **Declaration of Accuracy:**
  - I, the applicant, and/or the person applying on behalf, declare the above to be true, correct, and complete information under penalty that any false statements or hiding information made knowingly shall constitute a felony.
  - Any changes in income, assets, resources, residence, household membership, or medical insurance must be reported to Otero County Healthcare Services Department (OCHSD) within 14 days of change. Failure to report these changes may result in, loss of eligibility.
- **Obtain and Release of Information**:
  - I hereby give permission to any providers treating me to release my medical records and billing information to the OCHSD for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment.
  - I hereby give permission to the OCHSD to give limited information to approved State or Local agencies which give other related help for which I may be eligible.
  - I further authorize the OCHSD to make any inquiry of any person, firm, associate, public agency, institution, or corporation for financial, residential, medical, or any other information as may be requested and related to the Application. I further agree to save and hold harmless any person, firm, or corporation, including any financial institution or public agency from any liability whatsoever for the release of information relevant to this statement and the investigation of the facts pertinent to this application or a claim for financial assistance.
  - I know that the OCHSD will check the information that I give. OCHSD may use computers and/or any other means to check the information on Healthcare Assistance Program (HCAP) Application and any supporting documentation. OCHSD may also use third party sources to verify eligibility information.
  - 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 the OCHSD a copy of the trust document, including all attachments and related information. OCHSD will analyze the trust to see if it affects the benefits for which I am applying.
- **Statement of Understanding**:
  - I understand that as part of the provision of the OCHSD, Otero County may create and maintain 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.
- **Statement of Cooperation:**
  - I understand that I must cooperate with the OCHSD. The OCHSD reviews cases to ensure correct eligibility enrollment and payments.
  - I will give proof of things I report to OCHSD. If I cannot get proof, I know that I can ask the OCHSD to help me. Additionally, I hereby give permission to OCHSD to contact other people, companies, and agencies to obtain proof of statements I have made in my application.
- **Declaration of Identity for Minor Children:**
  - I am declaring the identity of the children under the age of 16 for whom I am applying.
- **Reimbursement for Overpayment**
  - I understand that if I receive benefits for which I am not eligible, that I may have to pay OCHSD back for those benefits. If I fail to do so, I, or the person(s) for whom I am applying, may lose eligibility coverage until the amount owed to OCHSD has been paid back in full.

Print Applicant's Name	Signature	Date
Print Name of Applicant's Representative	Signature	Date

Signature for additional household members over 18 applying for assistance		
Print Applicant's Name	Signature	Date
Print Applicant's Name	Signature	Date
Print Applicant's Name	Signature	Date