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State/Territory Name: New Mexico

State Plan Amendment (SPA) #: 13-0021 MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 714
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 12, 2014

Ms. Julie Weinberg, Director
Medical Assistance Division
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87504

Dear Ms. Weinberg:

Enclosed is an approved copy of New Mexico's (NM) state plan amendment (SPA) NM 13-0021-MM2, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 13, 2013. SPA NM 13-0021–MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into New Mexico's Medicaid state plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA NM 13-0021-MM2 includes approval of the state's alternative single streamlined paper application and the alternative paper application used to apply for multiple human service programs. The State is also using an interim alternative single streamlined online application and by December 31, 2014 will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of New Mexico's approved state plan:

- S94, pages S94-1, S94-2
- Attachment 1 - New Mexico Single Streamlined Application - Medical Assistance Only (Alternative Paper application)
- Attachment 2 - New Mexico Single Streamlined Application - All Programs (Alterative application used to apply for multiple human service programs)
- Attachment 3 – Statement of use with respect to the alternative single streamlined online application

In addition, enclosed is a summary of state plan pages which are superseded by NM SPA 13-0021-MM2, which should also be incorporated into a separate section in the front of the state plan.

- Superseding Pages of State Plan Material, 13-0021-MM2

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan amendment. For technical assistance with your online application, please contact Dena Greenblum at (410) 786-8684 or dena.greenblum@cms.hhs.gov. If you have any questions concerning this SPA, please contact Stacey Shuman at 214 767-6479 or by email at Stacey.Shuman@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

[redacted]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
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DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 12, 2014

Ms. Julie Weinberg, Director
Medical Assistance Division
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87504

Dear Ms. Weinberg:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) 13-0021-MM2, which was submitted to CMS on December 13, 2013. Our review of this submission included the review of New Mexico's alternative single streamlined online application.

Until December 31, 2014 the state is using an interim alternative single streamlined online application. This interim online application will need to be revised to reflect the following changes.

Necessary changes:	**Date by which changes will be completed:**
Questions about tax filing status will refer to whether the applicant plans to file taxes, not whether the applicant has filed taxes in the past.	December 31, 2014
The following questions will not appear for household members not seeking any benefits: • Questions regarding citizenship • Questions regarding residency • Questions regarding immigration status • Questions regarding disability and blindness	December 31, 2014

Questions regarding student status will only be asked when relevant to eligibility.	December 31, 2014
Applicants who do not appear eligible for Medicaid and CHIP based on income attestation will be asked whether they are offered health insurance from a job, and if so, will be asked additional details about that insurance offer.	December 31, 2014
Applicants will have the opportunity to identify themselves as American Indians and Alaska Natives for purposes of cost-sharing protections, and identify American Indian and Alaska Native income not countable for Medicaid and CHIP income determinations.	December 31, 2014

Please submit the revised alternative single streamlined online application to CMS for review no later than November 31, 2014 to ensure approval by December 31, 2014. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any other questions or require further assistance, please contact Stacey Shuman of my staff at either 214 767-6479 or by email at Stacey.Shuman@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

[redacted]

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **New Mexico**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NM-13-0021

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

S94: General Eligibility Requirements: Eligibility Process

Governor's Office Review

- **Governor's office reported no comment**
- **Comments of Governor's office received**
  Describe:
- **No reply received within 45 days of submittal**
- **Other, as specified**
  Describe:
  Authority Delegated to the Medicaid Director

Signature of State Agency Official

Submitted By:	**Caitlin Kuennen Breen**
Last Revision Date:	**Jan 15, 2014**
Submit Date:	**Dec 13, 2013**

Date Received: 12/13/13
Date Approved: 2/12/14
Signature of Regional Official: [redacted]
PRINTED NAME and Title: Bill Brooks, Associate Regional Administrator
Division of Medicaid and Children's Health

[redacted]

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0021-MM2	**STATE:** New Mexico
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN [06-01] Effective date:[07-01-2006], approved: [06-09-2006] Section 2, Page 11a, section 2.1(d), TN [91-19] Effective date: [10-01-1991], approved: [01-15-1992]

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: 13-0021-MM	**STATE:** New Mexico
Through December 31, 2014, the state is using an interim online alternative single streamlined application. After December 31, 2014, the state will use a revised online alternative single streamlined application, which will address the issues outlined in the CMS letter concerning the state's application. The revised application will be incorporated by reference into the state plan.	

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Information Sheet for Application for Assistance

HUMAN SERVICES DEPARTMENT

Human Services Department benefits:

Medicaid: Provides health care for certain people and families with low incomes and resources. Depending on your income and resources you may qualify for full or partial benefits.

Medicare Savings Program: Benefit that provides help with paying for your Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) premiums and Medicare deductibles.

Supplemental Nutrition Assistance Program (SNAP): Helps many low-income households buy the food they need to stay healthy, productive members of society.

Cash Assistance: Provides cash assistance for families, dependent needy children and disabled adults.

Low Income Home Energy Assistance Program (LIHEAP): Assists eligible Low Income families and individuals with their heating and cooling costs

Apply for the benefits above online at:
www.yes.state.nm.us/selfservice.

Or

Send your complete, signed application to your local Income Support Division office or mail it to:

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

Health Insurance Marketplace

Health Insurance Marketplace

- The marketplace is a way to shop for and compare health insurance plans for individuals and families who are not eligible for Medicaid.
- You may qualify for a program that can help you pay for a health insurance even if you earn as much as $94,000 a year (for a family of 4).
- New tax subsidies that can immediately help pay your premiums for health coverage may be available.

To apply for health insurance online through the Health Insurance Marketplace, you can go to:

www.bewellnm.com

Or

Call 1-855-99NMHIX (996-6449)
TTY: 1-855-889-4325

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APPLICATION FOR ASSISTANCE

Si Ud. necesita este formulario en español, comuníquese con su trabajador(a). Intérpretes están disponibles gratuitamente.

Check the assistance program(s) you are applying for: (adults not seeking assistance for themselves may apply on behalf of other household members)		Assistance Programs
☐	**MEDICAID** (If you or your household does not qualify for Medicaid, your application will be automatically forwarded to the Health Insurance Marketplace where you or your household may be eligible for other health insurance affordability programs.)	Depending on the income and resources and individual may qualify for full or partial benefits. The following are types of Medicaid that you may qualify for: • Newborns • Children up to age 18 • Parent(s)/Caretaker(s) • Pregnant women • Low-income adults • Emergency Services for Aliens **Complete Sections 1-10 & 16** • Aged, blind and disabled individuals • Working Disabled Individual • Institutional care • Home and Community Based Services Waiver **Complete Sections 1-10,12,13 & 16** **HEALTH INSURANCE MARKETPLACE** The marketplace is a way to shop for and compare health insurance plans. Individuals and families who are not eligible for Medicaid may be eligible to receive a new tax subsidy that can immediately help pay for health insurance premiums.
☐	**MEDICARE SAVINGS PROGRAM**	Medicaid benefit that provides help with paying for your Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) premiums and Medicare deductibles. **Complete Sections 1-6, 9,12,13 & 16**
☐	**SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)**	The Supplemental Nutrition Assistance Program (SNAP) helps many low-income households buy the food they need to stay healthy, productive members of society. SNAP benefits are simple to use when you purchase food at your grocery store. **Complete Sections 1-3, 5-8,11,12,14 & 16**
☐	**CASH ASSISTANCE**	Temporary Assistance for Needy Families (TANF), known in New Mexico as NMWorks, provides cash assistance to families who qualify. **or** General assistance can provide cash assistance for dependent needy children and disabled adults who are not eligible for assistance under a federally matched cash assistance program, such as New Mexico Works (NMW) or the Federal program of Supplemental Security Income (SSI). **Complete Sections 1-3, 5-8, 11,12,14 & 16**
☐	**Low Income Home Energy Assistance Program (LIHEAP)**	The Low Income Home Energy Assistance Program (LIHEAP) assists eligible Low Income Families and Individuals with their heating and cooling costs. **Complete Sections 1-3,5-8,12,13 & 16**

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Official Use Only	Status ❑ Application ❑ Redetermination	Former Recipient: ❑ Yes ❑ No	Expedite: ❑ Yes ❑ No	Cat.	Application Date	Date Mailed	Date Received

▶ Tell Us If You Need:	☐ Help Filling out the Application? ☐ Free Language Help? Language _____	☐ Transportation	☐ Disability Accommodation

▶ **Tell us why you prefer a telephone interview** (check one):

☐ Age 60+	☐ Working 20 or more hours/week	☐ Caring for a Child Under Age 6	☐ Caring for Others
☐ Live too Far from Office	☐ Transportation	☐ Bad Weather	☐ Other:
		☐ Disability	☐ Illness

1. Tell Us About You:

If you need help filling in this application or in 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	E-Mail Address	Best Time to Contact You

Street Address	City	County	State	Zip Code	Telephone Number ( )

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

Street or PO Box Address	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? If YES, please fill out your most current e-mail address above. ❑ Yes ❑ No

2. Person to Represent You (Authorized Representative or 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: ❑ Apply for benefits on your behalf? ❑ Use your benefit? (SNAP & Cash benefits only)

Name of Authorized Person(s)	Mailing Address	Preferred Telephone # / TDD
		( )
		( )

3. Tell us About the People who live with You:

Please list everyone that lives in your household even if you do not want to apply for them. You only have to give U.S. Citizenship and Social Security Numbers for those household members that you are applying for. Remember that you do not need to be a U.S. Citizen to apply. Receiving SNAP/food, energy or medical assistance will not prevent you from becoming a lawful permanent resident or U.S. Citizen. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information, Social Security Numbers, or other similar proofs; however, they must give proof of income and things they own because part of their income and things they own may count towards the household's eligibility for assistance. Certain benefits may be available for people without a Social Security Number; ask ISD. If needed, please use an additional sheet of paper for additional household members who do not fit on this page.

List the names and information for yourself and all the people who live with you:						Fill out this section only for each person applying for benefits.			
Name (First and Last)	Relationship	Sex 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.									

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5.									
6.									
7.									
8.									

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 you application today, please do not delay. SNAP/FOOD benefits start from the date you apply. To begin the process, you only need to fill out section 1 and sign. To receive help you must complete the whole application. You can bring, mail or fax the application to the ISD County office.

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

4. Please answer these Federal Income Tax Questions only about the people listed in Section 3 who will NOT be claimed as the applicant's tax dependents if they appear on a different tax return. ***Applicant can still get Medicaid if they don't file Federal taxes.**

Please list each individual tax filer and their dependent that are listed on the application, below.

Tax filer 1._____ Dependent Name:_____; Relationship:_____

Dependent Name:_____; Relationship:_____

Tax filer 2._____ Dependent Name:_____; Relationship:_____

Dependent Name:_____; Relationship:_____

Tax filer 3._____ Dependent Name:_____; Relationship:_____

Dependent Name:_____; Relationship:_____

5. Please Answer the Following Questions About the People You Listed in Section 3 who are seeking health coverage.

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

Who?_____; Document Type_____; ID Number:_____

Who?_____; Document Type_____; ID Number:_____

Who?_____; Document Type_____; ID Number:_____

Has any non-citizen applicant lived in the U.S. since 1996? Who _____

Is any non-citizen applicant or spouse or parent a veteran or on active duty with the U.S military? Who: _____

Is any applicant getting benefits in another state? If, YES, Who? _____	❑ Yes ❑ No
Is any applicant already in or going into a nursing home, hospital or treatment facility? Who? _____	❑ Yes ❑ No

If, YES, what type of facility: ❑ Nursing Home/ Nursing Facility ❑ Hospital ❑ PACE

❑ Intermediate Care facility for the Mentally Retarded (ICFMR) ❑ Other: If other, where? _____

Is anyone disabled? Who? _____	❑ Yes ❑ No

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Is any applicant in the household receiving Supplemental Security Income (SSI)? Who? _____Which State? _____	❑ Yes ❑ No
Is anyone in the household pregnant? Who? _____ How many babies are expected from this pregnancy? _____ Estimated Due Date _____ Name of the Father of the unborn? *(optional)* _____	❑ Yes ❑ No
Has any applicant received a ***Primary Freedom Of Choice*** letter for a Home and Community Based Services Waiver? If, YES, Who? _____	❑ Yes ❑ No
In any applicant a former Foster care recipient under the age of 26? If Yes, Who? _____	❑ Yes ❑ No

6. Tell Us About Your Earned Income

Note: If you are offered health insurance from any employer please fill out the Employer Coverage form attached to this application.

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

Person with income	Average number of hours worked?	Income from? (work, self employment, odd job)	How Often Received? (Yearly, Monthly, Biweekly, Weekly, etc)	How much do they receive?	Does this employer offer Health Insurance? (Y/N) If yes, fill out the employer coverage form attached.
				$	
				$	
				$	
				$	

Tell Us About Your Other 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?
			$
			$
			$

7. Will There be Changes in Income?

Do you or anyone living with you have changes in income that is not steady from month to month? ❑ Yes ❑ No

Examples include: Loss of job, decrease in hours, change in job, change in pay, and/or only working some of the months, out of the year? ❑ Don't know

Person	Income	When	Why

Deductions? (If applying for Medicaid or Health Insurance Marketplace only)

If you pay for certain things that can be deducted on a federal income tax return, tell us about them.

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❑ Alimony Paid $_____ How Often? _____ ❑ IRA Deductions $_____ How Often? _____

❑ Student Loan Interest $_____ How Often? _____

❑ Other: Type _____ How Much $_____ How Often? _____

❑ Other: Type _____ How Much $_____ How Often? _____

8. Parents Not Living with Their Children

By accepting medical assistance for your children, you assign (give) HSD rights to collect child support from an absent parent. Please list all the information for your children's parent(s) who are not living with you:

If you think cooperating to collect medical support will harm you or your children, you may not have to cooperate. Is any applicant a victim of Family Violence?	❑ Yes ❑ No

Child Name	Absent Parent Name (optional)

9. Health Care Information (If you are applying for Medicaid or Health Insurance Marketplace)

Has anyone in the household received medical services within the last 3 months that have not been paid? If yes, please list the members who have the bills and for which months. We may be able to help pay these bills. a._____; b._____; c._____	❑ Yes ❑ No
Does anyone in your household have health insurance?	❑ Yes ❑ No

If Yes, please list all public and private health insurance including Medicare information for you and all people living with you.

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

10. Managed Care Organization (MCO) (If you are applying for Medicaid on or after December 1, 2013) This section will ONLY apply if you are found to be eligible for Medicaid.

Beginning January 1, 2014 Medicaid services will provided by the four Managed Care Organizations (MCO(s) listed below. You have a choice of which MCO provides your services. If you do not choose an MCO by January 1, 2014, you will be automatically assigned to an MCO by the State. Once you are enrolled with an MCO, you will have the option to change the MCO within 90 days of enrollment.

Special information for Native Americans about Managed Care Organizations

If you are Native American, you are not required to choose an MCO. If you are in need of long- term care services or have Medicare, you will be required to choose one.

I am a Native American. ❑ Yes ❑ No (If yes, please complete the Native American or Alaskan Native information after this section)

Do you want to enroll in a Managed Care Organization? ❑ Yes ❑ No (If yes, please select an MCO below)

❑ Blue Cross Blue Shield (BCBS)

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 BCBS:_____

❑ Molina Healthcare of New Mexico

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

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❑ Presbyterian Health Plan	❑ United Healthcare Community Plan
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 Presbyterian:_____	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 United:_____

Native American or Alaska Native

Native American and Alaska Natives who enroll in Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs.

If you or your family members are Native American or Alaska Native, 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. **NOTE:** If you need more space please attach another piece of paper.

Is any applicant a member of a federally recognized tribe? If yes, Who? _____ What Tribe? _____	❑ Yes ❑ No
Do these 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 **no**, is this person 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

Certain money received may not be counted for Medicaid or CHIP.

Does the income reported in Section 6, include money from any of the following sources?

Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?	❑ Yes ❑ No If Yes, Who_____ $_____ How Often? _____
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 Often? _____
Money from selling things that have cultural significance?	❑ Yes ❑ No If Yes, Who_____ $_____ How Often? _____

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If you are not applying for the programs below, please complete section 16 and submit your application. If you are applying for the assistance programs below. Please only complete the required sections.

Section: 12, 13 & 16	Section: 11 through 16
• NURSING HOME • MEDICARE SAVINGS PROGRAM • WAIVER SERVICES • WORKING DISABLED INDIVIDUAL	• SNAP • CASH ASSISTANCE • LIHEAP

11. School Attendance

Fill this out if you are applying for SNAP and/or cash; list all student information for each household member.

Name of Student	Name of School	Graduation Date	Grade
			☐ K – 12 ☐ GED ☐ Certificate / College
			☐ K – 12 ☐ GED ☐ Certificate / College
			☐ K – 12 ☐ GED ☐ Certificate / College

12. Things you Own (Resources/Assets)

Certain resources/assets such as bank accounts may count toward your eligibility depending on which program you are applying for. 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).

Examples of things you own include, but are not limited to: Cash on hand, CD – Certificate of Deposit, royalties, life or burial insurance, checking account, trust(s), stocks or bonds, retirement account, livestock, house/land - not occupying, savings account or recreation vehicles.

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

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

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

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

C. Did you or anyone living with you transfer anything of value to others in the last 5 years (60 months)? ❑ Yes ❑ No

Item transferred	Transferred to whom?	$ Value	Date of Transfer?
		$	
		$	

13. Monthly Expenses

To get the most benefits you are eligible for, list all of your MONTHLY out-of-pocket expenses. Do not include amount paid by CYFD or other relatives.

Child Care or Adult Dependent Care ►	$	Mileage Round Trip for Dependent Care ►	$
Who/what agency is getting paid the Child Care expenses? _____			
Medical for Elderly/Disabled Including Medicare ►	$	Court Ordered Child Support? ►	$
Mortgage ►	$	Home Insurance Not included in Mortgage ►	$
Property Taxes Not included in Mortgage ►	$	Rent ►	$

Check any of the boxes that best describes your **Rent** type ☐ Homeless ☐ Public Housing ☐ Includes Utilities

Heating and Cooling ►	❑ Yes ❑ No	**Lifeline/Link-Up**: You may be eligible for telephone discounts on monthly service and initial telephone installation or activation fees. Contact your telephone provider for more information:
Water, Sewer and Trash ►	❑ Yes ❑ No	
Telephone ►	❑ Yes ❑ No	Telephone Company Name:

Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

14. Fill This Out if You are Applying for LIHEAP:

How much was your highest energy bill in the last 12 months?	$			Do you have a disconnect notice?	❑ Yes ❑ No
▼ Select the type of LIHEAP payment you want ▼				**Company Name:**	
❑ Electric	❑ Propane	❑ Wood	❑ Natural Gas	**Account Number:**	
❑ Pellets	❑ Coal	❑ Kerosene		**Account Name:**	

15. Please Answer the Following Questions About the People Listed in Section 3.

Buy and prepare meals together?	❑ Yes ❑ No	Disqualified from assistance program?	❑ Yes ❑ No
Fleeing Felon(s)?	❑ Yes ❑ No	Voluntarily quit job(s) in the last 60 days?	❑ Yes ❑ No
Living on a Native American Reservation? Name of Reservation? _____	❑ Yes ❑ No	Worker(s) on strike or lockout?	❑ Yes ❑ No
Getting Native American food commodities?	❑ Yes ❑ No	In violation of probation or parole?	❑ Yes ❑ No
Paying room and board?	❑ Yes ❑ No	Is anyone a veteran? Who? _____	❑ Yes ❑ No
Have you or any member of your household been convicted of receiving duplicate SNAP benefits?	❑ Yes ❑ No	Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives?	❑ Yes ❑ No
Getting Tribal TANF?	❑ Yes ❑ No		

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16. 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 State and Federal penalties and I have given HSD true, correct and complete information.**
- The filing date is different if the household is in an institution and applying for SNAP and SSI at the same time. The filing date will be the date of release from the institution.
- 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 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 get proof.
- I will let HSD 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 HSD back for those benefits.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
- I know that HSD will check the information that I give. HSD may use computers or other means 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 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 information sheet explaining my rights and responsibilities including, expedited SNAP/food assistance, SNAP/food penalties and program violations, fair hearing rights and more. I understand that these will also be explained to me during my appointment for an interview.
- 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. "Estate Recovery" is required where Medicaid recipients are fifty-five (55) years of age or older and the state makes medical assistance payments on their behalf for nursing facilities 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 exclusion's may apply.
- I understand that I must give HSD any money I receive for medical services which 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 Assistance shall assign to HSD all rights against any and all individuals for medical support or payments for medical expenses paid on the applicants' or client'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 in 42 CFR 435.923(d).
- To withdraw your application for any program, initial the box of the program ► ☐ **SNAP** ☐ **Medicaid** ☐ **Cash** ☐ **LIHEAP** ☐ **Marketplace**

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

SPECIAL NEEDS INFORMATION 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 through the New Mexico Relay System TDD at 1-800-659-8331 or by dialing 711. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (08/22/08)

17. Register to Vote

If YOU are NOT registered to vote where you live now, Would you like to register to vote here today? (Please check one) ☐ YES ☐ NO

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

The NATIONAL VOTER REGISTRATION ACT provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, 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.

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 in applying 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, 419 State Capital, Santa Fe, NM, 87503, (phone: 1-800-477-3632).**

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Program Application Information

(Applicant Information Pages)

1. Special Needs Information

SPECIAL NEEDS INFORMATION 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 through the New Mexico Relay System TDD at 1-800-659-8331 or by dialing 711. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (08/22/08)

2. Your Civil Rights

All programs administered by the Human Services Department (HSD) 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 New Mexico Human Services Department central office or the local Human Services county office.

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

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer. (04/01/2013)

3. Your Privacy

The information you give HSD will be used to determine whether your household is eligible or continues to be eligible to take part in HSD programs. 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. Non-Citizen Immigrants not requesting assistance for themselves do not need to give immigration status information or Social Security Numbers. Any Social Security Numbers given will be used and disclosed in the same manner as Social Security Numbers of eligible household members.

We also check with other agencies, the federal Income and Eligibility Verification Service (IEVS) and The Public Assistance Reporting Information System (PARIS) about the information that you give us. This information may affect your household eligibility and benefit amount.

4. Child Support Enforcement Division

By accepting cash or medical assistance, you assign (give) HSD rights to collect child support from the child'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 office to establish or enforce child support and you do not, cash benefits may be reduced and eventually lost, and adults may lose their medical assistance.

5. Interview

(a) How soon can I have my required appointment for an interview?

- Within 10 working days for SNAP/food and cash assistance, or for expedited SNAP/food assistance, the day you turn in your application
- Certain Medical assistance programs do not require an interview

(b) May I have a telephone interview?

You may have a telephone interview for any of these reasons:

- Age 60+
- Live too Far from Office
- Working 20 or more hours/week
- Transportation
- Disability
- Caring for a Child Under Age 6
- Bad Weather
- Illness
- Caring for Others
- Other Hardships

6. Proof Information

(a) How many days will I have to give all the required proof I need?

- 10 days from the date of your interview is best to receive benefits faster
- 30 days from the date of your application is typical – unless you need more time – If you need more time, ask for more time
- 60 days from the date of your application is the longest – **When you ask** for up to 3-ten-day extensions

If you do not ask for an extension of time to bring in proof, your case may be denied after 30 days.

(b) What proof should I bring to the interview?

During your interview appointment, your caseworker will ask you questions to determine if you are eligible for the programs for which you have applied. Your caseworker will **NOT** ask you to give proof of everything. You case as you can.

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Please refer to the chart called, Examples of Proof as a general guide to help you decide which proof items you will need. If your caseworker has unresolved questions about your eligibility, you will be asked to give proof. Your caseworker 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 your caseworker for help.

Examples of Proof

You do **NOT** have to give us all the items listed below; they are only examples. When you need to give proof, you only need to give one type from the examples below. If your caseworker has unresolved questions about your eligibility, you will be asked to give proof. Your caseworker 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 your caseworker for help.

	SNAP/food	Medical: Family or Adult	Medical: Child Only	Medical: Elderly/Disabled	Cash	Energy/LIHEAP	
▪ **Where you Live**	✓	✓	✓	✓	✓	✓	Utility bill, Rent agreement, letter addressed to you at your address
▪ **Social Security Number**							Social Security card or letter from the Social Security Administration (SSA) with your name & number
▪ **Identity**	✓			✓	✓	✓	You may give any of these if they prove identity, relationship or 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, U.S. Passport, school or day care records, insurance policies, church records or family bible, letter from a Dr., religious or school official, or someone who knows you, the child's relationship to you and knows the child's date of birth. **Note:** The Medicaid program will require specific identification proof.
▪ **Relationship**					✓		
▪ **Age**							
▪ **U.S. Citizenship**		✓	✓	✓			Most programs do not require proof of U.S. Citizenship. For medical assistance, the federal government now requires that all individuals give certain ORIGINAL documents (not copies) that verify Citizenship, Identity or proof or Legal Permanent Status. Original documents will be copied and returned. **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). **Proof of Citizenship Alone**: ▪ U.S. birth certificate. If you were born in New Mexico, HSD may be able to help you by checking with the Department of Health, Vital Records. Please give your caseworker your name, date of birth, county of birth, sex, mother's first and maiden name to get this help.
▪ **Immigrant Status**	✓	✓	✓	✓	✓	✓	If you are an immigrant applying for assistance, you may have to provide original USCIS (formerly the INS) records.
▪ **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**					✓		Medical records that say when your baby is due
▪ **School Attendance**							Current report card or letter from the school saying whether your child is attending school
▪ **College Student**	✓				✓		Letter from the college saying that you are either a part-time or full-time student
▪ **Student Financial Aid**	✓				✓	✓	Letter from the financial aid office stating what types and amounts of financial aid you get 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, a letter from the employer with the hours you will work and the pay you will get. If you are **self employed**, you may give your caseworker 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 etc.
▪ **Loss of a Job (60 days)**	✓	✓	✓	✓	✓	✓	Letter from the employer
▪ **Value of Things You Own**				✓			Resources/Assets: Recent bank statement or letter of value
▪ **Things You Transferred**	✓			✓	✓		Recent statement or letter of value
▪ **Health Insurance**		✓	✓	✓			ID card or letter from your insurance company
▪ **Medicare Part A**				✓			ID card or letter from Social Security Administration
▪ **Child Support Paid**	✓						If you want a deduction for child support you pay, give proof of both the legal responsibility to pay and the amount paid. Any court or administrative order, or legal separation agreement may be used. For proof of the amount, use cancelled checks, wage withholding statements, verification of withholding from unemployment compensation or written statements from the custodial parent.

Optional Proof – Below is a list of optional proof items that may help you can get the most benefits for which you are eligible. If there is no check in the box below then no proof is needed. To get credit, just tell us what you pay each month. You will only have to give proof if your caseworker has unresolved questions about your costs. If you are applying for energy/LIHEAP, please provide a copy of your heating/cooling cost. If you need help, ask your caseworker for help.

▪ **Child/Adult Care Costs**							You may give any of these if they prove your out-of-pocket costs: Agreement, computer printout, money order, letter from the person you pay, divorce or separation papers, statements, receipts, canceled check, copy of a check.
▪ **Medical Costs** Elderly or Disabled only	✓			✓			
▪ **Home Rent/Owner Costs**							

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▪ Heating/Cooling Costs						✓

7. Non-Citizen Immigrant Eligibility

(a) What types of Non-Citizen Immigrants are eligible for HSD assistance programs?

For most programs, non-citizens must have a "qualified" immigrant status and meet certain other conditions to qualify. Most non-citizens in the following categories can get benefits if they meet all other program eligibility requirements:

▪ Lawful Perm. Res. (LPRs)	▪ Refugees	▪ Asylees	▪ Cuban Haitian Entrants
▪ Amerasians	▪ Paroled to U.S. – 1 year	▪ Withholding of Deportation	
Certain:	▪ Battered women and children	▪ Veterans, active duty military	▪ Hmong or Laotian Tribe
	▪ Canada/Mexico born Native American	▪ Human Trafficking Victims	

Certain non-citizens, including undocumented non-citizens may be eligible for emergency medical services including pregnant women's labor and delivery.

(b) Is there a waiting period (bar) before non-citizen immigrants can get benefits?

The general rule now is that most qualified immigrant children are eligible to receive SNAP/food, Medical, Cash and Energy Assistance. However some "qualified" immigrant adults can get benefits after they have been in the United States in "qualified" immigrant status for five years, and some immigrants can get them right away. In general, adults in certain humanitarian immigration categories (such as Refugees and Asylees), people with military connections lawfully present pregnant women and children, credit for 10 years of work history in the US, and persons receiving disability benefits may be eligible right away.

8. After your Interview

(a) ***How soon will my application be approved or denied?***

- **SNAP/food** – No later than 30 calendar days after the date of application, or expedited SNAP/food - 7 calendar days
- **Medical** – No later than 45 calendar days after the date of application
- **Cash** – No later than 30 calendar days after the date of application, or up to 90 days for General Assistance disability decisions
- **Energy/LIHEAP** – No later than 30 calendar days after the date of application, or shut-off/disconnect crisis – 48 hours

(b) ***If I disagree with the eligibility decision or benefit level, can I have fair hearing?***

Yes - If you don't agree with a decision we make about your case, you can ask for a fair hearing in person, by telephone 1-800-432-6217 or (505) 827-8164, or in writing within 90-days of the date that a notice has been sent informing you of any action that has been taken on your case. Please mail your request to the HSD Hearing's Bureau at PO Box 2348 Santa Fe, NM 87504. You have a right to look at your case file and any records HSD used to determine your eligibility before your hearing. You can ask a household member or someone else like a friend or relative to represent your household at the fair hearing. You also have the right to have an attorney or other legal representative at the hearing.

(c) ***From what date are my benefits calculated?***

- **SNAP/food** – From the date you applied
- **Medical** – From the 1st day of the month you applied. You may be eligible for up to 3 prior months of Medicaid coverage.
- **Cash** – On the date HSD approves your application or the 30th day from the date of application, whichever is earlier
- **Energy/LIHEAP** – On the date HSD verifies your account with your energy provider

(d) ***How will I get my benefits?***

- **Medical** - A Medicaid card will be mailed to you one working day after the date of approval.
- **Energy/LIHEAP** - Your payment will be sent directly to your energy provider 7-days from the date HSD verifies your account information with your energy provider. For a shut-off/disconnect crisis, HSD will call your energy provider to help you avoid shut-off.
- **SNAP/food and Cash** – HSD uses an electronic debit card system called EBT to give you your cash and SNAP/food assistance benefits. If you have never had an EBT card, an EBT card will be mailed to your address in one working day after the date you apply and after your application is registered on the computer. If your EBT card is delayed you may request a card from your local ISD office. You may call EBT Customer Service 24 hours 7- days/week at 1-800-843-8303 to order a replacement or activate your EBT card.

Each month your cash benefit will be deposited in your EBT account on the first day of the month. Your SNAP/food benefits will be deposited in your EBT account on the day of the month in the box below that lists the last two digits of the head of household's social security number.

Combined Schedule: If you have applied for SNAP/Food assistance after the 15th day of any month and are approved for expedited assistance, you will receive your benefits according to the schedule below.

- You will receive your 1st and 2nd month's benefits the day after your case is approved.
- You will receive your 3rd month's benefits on the 1st day of the month.
- You will receive your 4th month's benefits within the first 10 days of the month, depending on the last two digits of your SSN.

You will receive your 5th month's benefits within the first 20 days of the month, depending on the last two digits of your SSN. This will be your regular day of the month to receive your future SNAP/Food Stamp benefit.

SNAP/Food Assistance *Compressed Staggered* Issuance Schedule

Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	Day	SSN	Day	SS

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	11		01		12		02		13		03		14		04		15		05
	31		21		32		22		33		23		34		24		35		25
	51		41		52		42		53		43		54		44		55		45
	71		61		72		62		73		63		74		64		75		65
1	91	**2**	81	**3**	92	**4**	82	**5**	93	**6**	83	**7**	94	**8**	84	**9**	95	**10**	85
	16		06		17		07		18		08		19		09		10		00
	36		26		37		27		38		28		39		29		30		20
	56		46		57		47		58		48		59		49		50		40
	76		66		77		67		78		68		79		69		70		60
	96		86		97		87		98		88		99		89		90		80

SNAP/Food Assistance *Staggered* Issuance Schedule

Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN
	11		01		12		02		13		03		14		04		15		05
	31		21		32		22		33		23		34		24		35		25
1	51	**2**	41	**3**	52	**4**	42	**5**	53	**6**	43	**7**	54	**8**	44	**9**	55	**10**	45
	71		61		72		62		73		63		74		64		75		65
	91		81		92		82		93		83		94		84		95		85
	16		06		17		07		18		08		19		09		10		00
	36		26		37		27		38		28		39		29		30		20
11	56	**12**	46	**13**	57	**14**	47	**15**	58	**16**	48	**17**	59	**18**	49	**19**	50	**20**	40
	76		66		77		67		78		68		79		69		70		60
	96		86		97		87		98		88		99		89		90		80

(e) ***How long can I get benefits before I have to renew them?***

- **SNAP/food** – Up to 12 months is typical or 24 months for elderly/disabled households with stable unearned income such as Social Security
- **Medical** – Up to 12 months is typical
- **Cash** – Up to 12 months at a time is typical. Adults age 18 and over can receive TANF benefits for no more than 60 months during their lifetime, unless they qualify for a hardship extension after they reach the limit. A child living with a parent who is ineligible due to the time limit is ineligible for TANF as a child. The 60-month limit does not apply to cases where the children qualify for TANF and the parent is ineligible for a reason other than the 60-month limit, such as receipt of SSI or an unqualified immigrant status. The 60-month limit does not apply to medical or SNAP assistance.

(f) ***Do I have to report changes?*** **Always report address changes** within 10 calendar days for all types of assistance programs.

- **SNAP/food and Cash** - Changes in household members, monthly household costs, income/job and resources:
  Report these types of changes within 10 calendar days from the date the change happened only if:
  1. the change(s) will cause your case to close; or
  2. the change(s) will cause your benefits to increase
  - **Semi-Annual Reporting:** Most households will be mailed a semi-annual report where all changes must be reported and given to ISD.
  - **Annual Reporting:** Households that get fixed income like Social Security will be mailed an annual report where all changes must be reported and sent to the ISD office.
  - **Regular Reporting:** There are few households that have to report changes as they happen. These households must report all changes within 10 calendar days from the date the change happened.
- **Medical –** For Elderly and Disabled persons, report all changes within 10 calendar days. For families with children and childless adults, you only have to report address changes within 10 calendar days. All other changes will have to be reported the next time you renew your case.

(g) ***Will I have to take part in a Work Program?***

- **SNAP/food –** Yes, unless you are excused or exempt, household members age 18 to 50 are required to participate with the SNAP Employment and Training (E&T) Program. You may request to voluntarily participant in a work activity through the E&T Program. Whether or not you choose to participate in the E&T Program will not affect your SNAP benefits. Participation provides you the opportunity to participate in a work readiness activity and you may receive support services and reimbursements. You may be contacted by the New Mexico Works (NMW) service provider. When you meet the following situations, you may be excused:

▪ Caring for an incapacitated person	▪ Receiving Unemployment Compensation	▪ Physically or mentally unfit for employment
▪ College student(s) enrolled at least part-time	▪ Complying with TANF/NMW Program	▪ Participating in a drug/alcohol treatment program
▪ Employed at least 30 hrs./wk or receiving weekly earnings = to the Federal min. wage x 30 hours	▪ Individual younger than 18 years of age or age 50 years or older	▪ Natural parent, adopted or step parent or individual residing in a SNAP household that includes a child under age 18, even if the child is not eligible for SNAP benefits
▪ Pregnant Women	▪ Residing in a county with greater than 10% Unemployment Rate	

- **Cash** – Yes, all adults getting TANF cash assistance participate in the New Mexico Works Program. You will be contacted by the New Mexico Works (NMW) service provider. When you do not complete or report your work activity, you can lose some and eventually all of your cash assistance. This is called a sanction. The first time, we will want to talk with you to try and correct the sanction before it happens; this is called conciliation. A sanction will reduce your benefits in the following three ways: **1st Sanction – 25% cash reduction; 2nd – 50% cash reduction; and the 3rd – Case Closure.** When you meet any of the following situations, you may be excused only after HSD reviews and approves your request to be excused:

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▪ Single Parent Caring for a Child under 12 Months Old – Lifetime limit	▪ Temporary Personal Situations – Up to 30 days
▪ Age 60 or Older	▪ Disabled
▪ Pregnant in Third Trimester or Six weeks post partum	▪ Caring for a Ill or Incapacitated Household Member
▪ Single Parent caring for a Child under 6 years old (no childcare)	▪ Domestic Violence (Family Violence Option)
▪ Impaired, temporarily or permanently, as determined by IRU	▪ Good cause for the need of Limited Work Participation status

(h) ***What types of support services can I get?***

The NMW service provider will refer you to supportive services such as child care, transportation, English as a Second Language, getting your GED, college or vocational school, substance abuse and domestic violence counseling/services. For these and additional services where you live please visit: http://www.hsd.state.nm.us/isd/fieldoffices.html.

9. Important Information About Your EBT Card

(a) First EBT Card

If this is your first SNAP/Food or Cash assistance case with the New Mexico Human Services Department, your EBT card will be mailed to you on the first working day after your application is entered into the ISD computer system by the local ISD office.

You should receive your EBT card within 7 days of applying. If 7 days have passed, and you have not received your card, please contact the EBT Help Desk at 1-800-283-4465 so arrangements can be made for you to pick up a card at the local county ISD office.

You must activate your card when you get it. You need to get a Personal Identification Number (PIN) from JP Morgan. To activate your card and get a PIN, please call 1-800-843-8303 24 hours a day or 1-800-283-4465, Monday-Friday, 8:00am to 5:00pm. If you have any questions regarding the EBT card procedure, please call 1-800-283-4465.

Important

If you have an EBT card and order a new one, you will not be able to access your benefits until the new one is activated with a new PIN. The old card will be disabled.

(b) I have an EBT Card that I know works.

If you have received SNAP/Food or Cash Assistance in the past and know that your EBT card works, please let ISD know that you do not need a new card. You will be able to access your benefits once your case is approved.

If you only forgot your PIN number, but your card still works, please call 1-800-843-8303 - 24 hours a day or 1-800-283-4465, Monday-Friday, 8:00am to 5:00pm, to get a new PIN. If you have any questions regarding the EBT card procedure, please call 1-800-283-4465.

(c) My EBT Card does not work.

If you have received SNAP/Food or Cash assistance in the past and your EBT card does not work, please call the JP Morgan Customer Service Desk at 1-800-843-8303 or 1-800-283-4465. Your new EBT card will be mailed to you on the first working day after you request one from the JP Morgan Customer Service Desk.

You should receive your EBT card within 7 days of date of applying. If 7 days have passed, and you have not received your card, please contact the EBT Help Desk at 1-800-283-4465 so arrangements can be made for you to pick up a card at the local county ISD office.

You must activate your card when you get it. You need to get a Personal Identification Number (PIN) from JP Morgan. To activate your card and get a PIN, please call 1-800-843-8303 - 24 hours a day or 1-800-283-4465, Monday-Friday, 8:00am to 5:00pm. If you have any questions regarding the EBT card procedure, please call 1-800-283-4465.

(d) I lost my card.

If you have received SNAP/Food or Cash assistance in the past and your EBT card does not work, please call the JP Morgan Customer Service Desk at 1-800-843-8303 or 1-800-283-4465. Your new EBT card will be mailed to you on the first working day after you request one from the JP Morgan Customer Service Desk.

You should receive your EBT card within 7 days of date of applying. If 7 days have passed, and you have not received your card, please contact the EBT Help Desk at 1-800-283-4465 so arrangements can be made for you to pick up a card at the local county ISD office.

You must activate your card when you get it. You need to get a Personal Identification Number (PIN) from JP Morgan. To activate your card and get a PIN, please call 1-800-843-8303 - 24 hours a day or 1-800-283-4465, Monday-Friday, 8:00am to 5:00pm. If you have any questions regarding the EBT card procedure, please call 1-800-283-4465.

10. Penalties for SNAP/food Assistance Violations

You must not give false information or hide information to get SNAP/food assistance, including EBT cards. You must not trade or sell your EBT card or your PIN. You must not allow a retailer to debit your EBT account in exchange for cash. You must not change EBT cards to get SNAP/food assistance you are not eligible to receive. Do not use, or have in your possession, EBT card that are not yours and do not let someone else use your card. You must not use your SNAP/food assistance benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's EBT card for your household.

Anyone intentionally breaking any of these rules could be barred from receiving SNAP/food assistance for 12 months (1st violation); barred for 24 months (2nd violation); barred permanently (3rd violation); subject to $250,000 fine, imprisoned up to 20 years, or both; suspended for an additional 18 months. Anyone intentionally breaking these rules could also be prosecuted u al penalties.

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Anyone who intentionally gives false information or hides information about identity or residence to get SNAP/food assistance in more than one household at the same time could be barred for 10 years.

Anyone convicted of trading food stamps for a controlled substance could be barred from receiving SNAP/food assistance for 24 months (1st violation) and barred permanently (2nd violation).

Anyone convicted for trading SNAP/food for firearms, ammunition, or explosives could be barred permanently (1st violation). Anyone convicted for trading or selling SNAP/food assistance of $500 or more and anyone convicted of a drug-related felony will be barred permanently.

11. Notice of Rights

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 federal and state agencies. All information will be used to determine eligibility and/or to provide services. (03/29/12)

CIVIL RIGHTS STATEMENT All programs administered by the Human Services Department (HSD) 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 New Mexico Human Services Department central office, ATTN: Quality Improvement Section, Pollon Plaza, P. O. Box 2348, Santa Fe, New Mexico 87504-2348 or the local Human Services county office. Complaints of discrimination about the Supplemental Nutrition Assistance Program may be filed with the USDA, Director, Office of Adjudication, 1400 Independence Ave, S.W. Washington, DC 20250-9410 or call 1-866-632-9992 or 202-401-0216 (TDD). Complaints of discrimination about Cash Assistance and Medical Assistance programs may be filed with the Office of Civil Rights, Department of Health & Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202 or call 1-800-368-1019 (voice) and 1-214-767-8940 (TDD). (08/16/11)

YOUR RIGHT TO A HEARING - 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. You can ask for an HSD hearing by:

- Completing and returning the bottom of a notice;
- Writing or calling your local HSD office; or
- Writing the department's Hearings Bureau at Human Services Department, P.O. Box 2348, Santa Fe, N.M. 87504-2348, or by calling 1-800-432-6217 (press 6) or 505-476-6213. (Revised 08/16/11)
- Marketplace HEARING - I know that if I believe the Marketplace has made a mistake about my eligibility, I may appeal the action by contacting the Health Insurance Exchange at 1-800-318-2596 and properly inform it that I believe their action should be reviewed. I know I may authorize someone else to represent me in the appeals process.

TIME LIMIT FOR ASKING FOR A HEARING - You have 90 days from the date of this notice to ask for a hearing. If you ask for a hearing within 13 days from the date of this notice, you will continue to get the same amount of benefits you received before we took the action in this notice. You will continue to get these benefits until the Department decides your case, unless another change is made to 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 the Department decided your case. (Revised 9/24/02)

THE HEARING PROCESS - After you ask for a hearing, the Department or Marketplace will send you a letter telling you the date, time and place where your hearing will be held. The hearing is usually at the HSD county office. The hearing will be conducted by a hearing officer from the HSD Hearings Bureau or the Marketplace. You or your representative can look at your case record and any proof we used to decide your case. You will tell why you believe HSD's or Marketplace action was wrong. You may bring witnesses and present proof. You may question the county office or the Marketplace about the action taken and proof presented. You may represent yourself. 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 Marketplace Executive Director will decide whether the action was right or wrong. After the Director has decided your case, you will be sent a letter telling you of the decision and why the decision was made. (Revised 04/02/03)

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Employer Coverage Form

Applying for help with health insurance costs from the Health Insurance marketplace?

The Health Insurance Marketplace 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.

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 a Health Insurance Marketplace application.

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.

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

What's 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_____

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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	Site Code

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

POLITICAL PARTY			DAY TIME TELEPHONE NUMBER (Optional)		POLL WORKER
5	NOTE: You must name a major political party to vote in primary elections. ➡ ➡ ➡	Party	If you choose NO PARTY, Check this box ❑	6	May the County Clerk make this telephone number public for election purposes? ❑ Yes ❑ No	Would you like to serve as an election day precinct worker? ❑ Yes

7	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:

8 Are you a citizen of the United States? ..... ❑ Yes ❑ No
Will you be 18 years of age on or before election day? ..... ❑ 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
_____/_____/_____

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 the 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 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 the information I have provided is correct.

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

9 Name of agent who assisted you in filling out this form.

VRA ID #

DO NOT WRITE IN SHADDED AREAS – FOR OFFICIAL USE ONLY

Accepted for filing in County Registration Records:
_____/_____/_____
Date County Clerk Filing Clerk

ID SCHOOL	PCT CC	MUN	PRG DIST	REP	DIST SEN	DIST

NMVR-1 HSD (2012)

Registrarse para Votar

HSD Site Code I-

INFORMACION PERSONAL					
1	NOMBRE: Apellido	Su Nombre de Pila	Otro Nombre o Inicial	Género	Fechade Nacimiento	Número de Seguro Social

DIRECCION DONDE UD. VIVE AHORA			
2	Número y Nombre de la Calle	Departamento, Unidad o # de Lote	Ciudad	Zona Postal

DIRECCION DONDE UD. RECIBE SU CORRESPONDENCIA			
3	Dirección	Ciudad	Zona Postal	Site Code

4	¿Si Ud. Va cambier su nombre en esta solicitud, bajo que nombre completo estaba Ud. Matriculado antes?	Apellido	Nombre de Pila	Otro Nombre o Inicial

PARTIDO POLITICO		NUMERO DE TELEFONO EN EL DIA (Opcional)		EMPLEADO / A EN URNA ELECTORAL
5	AVISO: Ud. tiene que indicar partido politico principal para votar en la elección primaria ➡ ➡ ➡	Partido	Si Ud. NO ELIGE Partido marque aquí ❑	6	¿Con motivo del elecciones puede divulgar el escribano de Condado esté núm. De teléfono? ❑ Si ❑ No	¿Quiere Ud. trabajar en recinto electoral el dia de la elección? ❑ Si

7	Por la presente autorizo que Ud. cancele mi matrícula previa en el condado y estado a continuación.	Ciudad o División	Condado	Estado

Favor de contestar las preguntas a continuación:

8 ¿Es Ud. ciudadano / a de los Estados Unidos? ..... ❑ Si ❑ No
¿Habrá cumplido Ud. 18 años en o antes del dia de la elección? ❑ Si ❑ No
Si Ud. marcó "NO" en cualquiera de las preguntas más arriba no termine de rellenar este formulario.
Si usted fue condenado de un delito grave y actualmente esta en libertad condicional o probación supervisada, no llene esta forma.

➡ **FECHA:**
Mes Dia Año
_____/_____/_____

TESTIMONIO DE CALIFICACION

Yo juro/afirmo que soy ciudadano de los Estados Unidos y residente del Estado de Nuevo México; que la corte no me ha denegado el derecho de votar por motivo de incapacidad psicológica; que tengo o tendré 18 años de edad en la fecha de la próxima elección y si he sido condenado de delito grave he cumplido todas las condiciones de libertad a prueba o el gobernador me ha concedido indulto. Ademas, juro o afirmo que autorizo la cancelación de toda matricula anterior con el fin de votar en el territorio de mi residencia previa; y que la informacion proveido esta correcto.

➡ FIRME SU NOMBRE COMPLETO O MARQUE LA LÍNEA ABAJO:

9 Nombre de la persona que le ayudó a llenar este formulario:

VRA ID #

NO ESCRIBA EN LOS ESPACIOS EN COLOR GRIS – SOLO PARA USO OFICIAL

Accepted for filing in County Registration Records
_____/_____/_____
Date County Clerk Filing Clerk

ID SCHOOL	PCT CC	MUN	PRG DIST	REP	DIST SEN	DIST

ISDB 720 Issued 3/5/12

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Information Sheet for Medicaid Application for Assistance

HUMAN SERVICES DEPARTMENT

Human Services Department benefits:

Medicaid: Provides health care for certain people and families with low incomes and resources. Depending on your income and resources you may qualify for full or partial benefits. *(If you do not qualify for Medicaid, your application will be automatically forwarded to the Health Insurance Marketplace where you may be eligible for other health insurance affordability programs.)*

Depending on your income you may qualify for full or partial benefits. The following are types of Medicaid that you may qualify for:

- Newborns
- Children up to age 18
- Parent(s)/Caretaker(s)
- Pregnant women
- Low-income adults
- Emergency Services for Aliens

Apply for the benefits above online at: www.yes.state.nm.us/selfservice.

Or

Send your complete, signed application to your local Income Support Division office or mail it to:

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

Health Insurance Marketplace

Health Insurance Marketplace

- The marketplace is a way to shop for and compare health insurance plans for individuals and families who are not eligible for Medicaid.
- You may qualify for a program that can help you pay for a health insurance even if you earn as much as $94,000 a year (for a family of 4).
- New tax subsidies that can immediately help pay your premiums for health coverage may be available.

To apply for health insurance online through the Health Insurance Marketplace, you can go to:

www.bewellnm.com

Or

Call 1-855-99NMHIX (996-6449)
TTY: 1-855-889-4325

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MEDICAID APPLICATION FOR ASSISTANCE

Si Ud. necesita este formulario en español, comuníquese con su trabajador(a). Intérpretes están disponibles gratuitamente.

Check the assistance program(s) you are applying for: (adults not seeking assistance for themselves may apply on behalf of other household members)	**Assistance Programs**
MEDICAID (If you or your household does not qualify for Medicaid, your application will be automatically forwarded to the Health Insurance Marketplace where you or your household may be eligible for other health insurance affordability programs.)	Depending on your income an individual may qualify for full or partial benefits. The following are types of Medicaid that you may qualify for: • Newborns • Children up to age 18 • Parent(s)/Caretaker(s) • Pregnant women • Low-income adults • Emergency Services for Aliens
	HEALTH INSURANCE MARKETPLACE The marketplace is a way to shop for and compare health insurance plans. Individuals and families who are not eligible for Medicaid may be eligible to receive a new tax subsidy that can immediately help pay for health insurance premiums.

1. Tell Us About You:

If you need help filling in this application or in 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		E-Mail Address		Best Time to Contact You	
Street Address	City	County	State	Zip Code	Telephone Number ( )

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

Street or PO Box Address	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? If YES, please fill out your most current e-mail address above.		❑ Yes ❑ No	

2. Person to Represent You (Authorized Representative or 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: ❑ Apply for benefits on your behalf?

Name of Authorized Person(s)	Mailing Address	Preferred Telephone # / TDD
		( )
		( )

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3. Tell us About the People who live with You:

Please list everyone that lives in your household even if you do not want to apply for them. You only have to give U.S. Citizenship and Social Security Numbers for those household members that you are applying for. Remember that you do not need to be a U.S. Citizen to apply. Receiving SNAP/food, energy or medical assistance will not prevent you from becoming a lawful permanent resident or U.S. Citizen. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information, Social Security Numbers, or other similar proofs; however, they must give proof of income and things they own because part of their income and things they own may count towards the household's eligibility for assistance. Certain benefits may be available for people without a Social Security Number; ask ISD. If needed, please use an additional sheet of paper for additional household members who do not fit on this page.

List the names and information for yourself and all the people who live with you:						Fill out this section only for each person applying for benefits.			
Name (First and Last)	Relationship	Sex 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.									
5.									
6.									
7.									
8.									

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.

4. Please answer these Federal Income Tax Questions only about the people listed in Section 3 who will NOT be claimed as the applicant's tax dependents if they appear on a different tax return. *Applicant can still get Medicaid if they don't file Federal taxes.

Please list each individual tax filer and their dependent that are listed on the application, below.

Tax filer 1._____ Dependent Name:_____; Relationship:_____

Dependent Name:_____; Relationship:_____

Tax filer 2._____ Dependent Name:_____; Relationship:_____

Dependent Name:_____; Relationship:_____

Tax filer 3._____ Dependent Name:_____; Relationship:_____

Dependent Name:_____; Relationship:_____

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5. Please Answer the Following Questions About the People You Listed in Section 3 who are seeking health coverage.

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

Who?_____; Document Type_____; ID Number:_____

Who?_____; Document Type_____; ID Number:_____

Who?_____; Document Type_____; ID Number:_____

Has any non-citizen applicant lived in the U.S. since 1996? Who _____

Is any non-citizen applicant or spouse or parent a veteran or on active duty with the U.S military? Who: _____

Is any applicant getting benefits in another state? If, YES, Who? _____	❑ Yes ❑ No
Is any applicant already in or going into a nursing home, hospital or treatment facility? Who? _____	❑ Yes ❑ No

If, YES, what type of facility: ❑ Nursing Home/ Nursing Facility ❑ Hospital ❑ PACE

❑ Intermediate Care facility for the Mentally Retarded (ICFMR) ❑ Other: If other, where? _____

Is anyone disabled? Who? _____	❑ Yes ❑ No
Is any applicant in the household receiving Supplemental Security Income (SSI)? Who? _____Which State? _____	❑ Yes ❑ No
Is anyone in the household pregnant? Who? _____ How many babies are expected from this pregnancy? _____ Estimated Due Date _____ Name of the Father of the unborn? (*optional*)_____	❑ Yes ❑ No
Has any applicant received a ***Primary Freedom Of Choice*** letter for a Home and Community Based Services Waiver? If, YES, Who? _____	❑ Yes ❑ No
In any applicant a former Foster care recipient under the age of 26? If Yes, Who? _____	❑ Yes ❑ No

6. Tell Us About Your Earned Income

Note: If you are offered health insurance from any employer please fill out the Employer Coverage form attached to this application.

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

Person with income	Average number of hours worked?	Income from? (work, self-employment, odd job)	How Often Received? (Yearly, Monthly, Biweekly, Weekly, etc)	How much do they receive?	Does this employer offer Health Insurance? (Y/N) If yes, fill out the employer coverage form attached.
				$	
				$	
				$	
				$	

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Tell Us About Your Other Income:

Examples of unearned income include, but are not limited to: Unemployment, Social Security, pensions, retirement, rental income, Indian monies, capital gains, dividends/interest, and per capita payments. **Note**: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI)

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

7. Will There be Changes in Income?

Do you or anyone living with you have changes in income that is not steady from month to month? ❑ Yes ❑ No

Examples include: Loss of job, decrease in hours, change in job, change in pay, and/or only working some of the months, out of the year? ❑ Don't know

Person	Income	When	Why

Deductions?

If you pay for certain things that can be deducted on a federal income tax return, tell us about them.

❑ Alimony Paid $_____ How Often? _____ ❑ IRA Deductions $_____ How Often? _____

❑ Student Loan Interest $_____ How Often? _____

❑ Other: Type _____ How Much $_____ How Often? _____

❑ Other: Type _____ How Much $_____ How Often? _____

8. Parents Not Living with Their Children

By accepting medical assistance for your children, you assign (give) HSD rights to collect child support from an absent parent. Please list all the information for your children's parent(s) who are not living with you:

If you think cooperating to collect medical support will harm you or your children, you may not have to cooperate. Is any applicant a victim of Family Violence? ❑ Yes ❑ No

Child Name	Absent Parent Name (optional)

9. Health Care Information

Has anyone in the household received medical services within the last 3 months that have not been paid? If yes, please list the members who have the bills and for which months. We may be able to help pay these bills. a._____; b._____; c._____ ❑ Yes ❑ No

Does anyone in your household have health insurance? ❑ Yes ❑ No

If Yes, please list all public and private health insurance including Medicare information for you and all people living with you.

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

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10. Managed Care Organization (MCO) (If you are applying for Medicaid on or after December 1, 2013) This section will ONLY apply if you are found to be eligible for Medicaid.

Beginning January 1, 2014 Medicaid services will provided by the four Managed Care Organizations (MCO(s) listed below. You have a choice of which MCO provides your services. If you do not choose an MCO by January 1, 2014, you will be automatically assigned to an MCO by the State. Once you are enrolled with an MCO, you will have the option to change the MCO within 90 days of enrollment.

Special information for Native Americans about Managed Care Organizations

If you are Native American, you are not required to choose an MCO. If you are in need of long- term care services or have Medicare, you will be required to choose one.

I am a Native American. ❑ Yes ❑ No (If yes, please complete the Native American or Alaskan Native information after this section)

Do you want to enroll in a Managed Care Organization? ❑ Yes ❑ No (If yes, please select an MCO below)

❑ **Blue Cross Blue Shield (BCBS)** 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 BCBS:_____	❑ **Molina Healthcare of New Mexico** 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 Molina:_____
❑ **Presbyterian Health Plan** 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 Presbyterian:_____	❑ **United Healthcare Community Plan** 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 United:_____

Native American or Alaska Native

Native American and Alaska Natives who enroll in Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs.

If you or your family members are Native American or Alaska Native, 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. **NOTE:** If you need more space please attach another piece of paper.

Is any applicant a member of a federally recognized tribe? If yes, Who? _____ What Tribe? _____	❑ Yes ❑ No
Do these 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 **no**, is this person 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

Certain money received may not be counted for Medicaid or CHIP.

Does the income reported in Section 6, include money from any of the following sources?

Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?	❑ Yes ❑ No If Yes, Who_____ $_____ How Often? _____

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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 Often? _____
Money from selling things that have cultural significance?	❑ Yes ❑ No If Yes, Who_____ $_____ How Often? _____

11. 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 State and Federal penalties and 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.
- 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 get proof.
- I will let HSD 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 HSD back for those benefits.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
- I know that HSD will check the information that I give. HSD may use computers or other means 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 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.
- 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. "Estate Recovery" is required where Medicaid recipients are fifty-five (55) years of age or older and the state makes medical assistance payments on their behalf for nursing facilities 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 exclusion's may apply.
- I understand that I must give HSD any money I receive for medical services which 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 Assistance shall assign to HSD all rights against any and all individuals for medical support or payments for medical expenses paid on the applicants' or client'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 in 42 CFR 435.923(d).
- To withdraw your application for any program, initial the box of the program ► ☐ **Medicaid** ☐ **Marketplace**

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

SPECIAL NEEDS INFORMATION 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 through the New Mexico Relay System TDD at 1-800-659-8331 or by dialing 711. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (08/22/08)

12. Register to Vote

If YOU are NOT registered to vote where you live now, Would you like to register to vote here today? (Please check one) ☐ YES ☐ NO
IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

The NATIONAL VOTER REGISTRATION ACT provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, 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.

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 in applying 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, 419 State Capital, Santa Fe, NM, 87503, (phone: 1-80**

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Program Application Information

(Applicant Information Pages)

1. Special Needs Information

SPECIAL NEEDS INFORMATION 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 through the New Mexico Relay System TDD at 1-800-659-8331 or by dialing 711. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (08/22/08)

2. Your Civil Rights

All programs administered by the Human Services Department (HSD) 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 New Mexico Human Services Department central office or the local Human Services county office.

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

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

3. Your Privacy

The information you give HSD will be used to determine whether your household is eligible or continues to be eligible to take part in HSD programs. 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. Non-Citizen Immigrants not requesting assistance for themselves do not need to give immigration status information or Social Security Numbers. Any Social Security Numbers given will be used and disclosed in the same manner as Social Security Numbers of eligible household members.

We also check with other agencies, the federal Income and Eligibility Verification Service (IEVS) and The Public Assistance Reporting Information System (PARIS) about the information that you give us. This information may affect your household eligibility and benefit amount.

4. Child Support Enforcement Division

By accepting medical assistance, you assign (give) HSD rights to collect child support from the child'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 office to establish or enforce child support and you do not, benefits may be eventually lost, and adults may lose their medical assistance.

5. Interview

How soon can I have my required appointment for an interview?

- The Medical assistance programs on this application do not require an interview.

6. Proof Information

(a) How many days will I have to give all the required proof I need?

- 10 days from the date of your application is best to receive benefits faster
- 45 days from the date of your application is typical – unless you need more time – If you need more time, ask for more time
- 60 days from the date of your application is the longest – **When you ask** for up to 3-ten-day extensions

If you do not ask for an extension of time to bring in proof, your case may be denied after 30 days.

(b) What proof should I bring to the interview?

Your caseworker will **NOT** ask you to give proof of everything. You should be ready to give as many facts about your case as you can. If your caseworker has unresolved questions about your eligibility, you will be asked to give proof. Your caseworker 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 your caseworker for help.

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7. Non-Citizen Immigrant Eligibility

(a) What types of Non-Citizen Immigrants are eligible for HSD assistance programs?

For most programs, non-citizens must have a "qualified" immigrant status and meet certain other conditions to qualify. Most non-citizens in the following categories can get benefits if they meet all other program eligibility requirements:

▪ Lawful Perm. Res. (LPRs)	▪ Refugees	▪ Asylees	▪ Cuban Haitian Entrants
▪ Amerasians	▪ Paroled to U.S. – 1 year	▪ Withholding of Deportation	
Certain:	▪ Battered women and children	▪ Veterans, active duty military	▪ Hmong or Laotian Tribe
	▪ Canada/Mexico born Native American	▪ Human Trafficking Victims	

Certain non-citizens, including undocumented non-citizens may be eligible for emergency medical services including pregnant women's labor and delivery.

(b) Is there a waiting period (bar) before non-citizen immigrants can get benefits?

The general rule now is that most qualified immigrant children are eligible to receive Medical Assistance. However some "qualified" immigrant adults can get benefits after they have been in the United States in "qualified" immigrant status for five years, and some immigrants can get them right away. In general, adults in certain humanitarian immigration categories (such as Refugees and Asylees), people with military connections lawfully present pregnant women and children, credit for 10 years of work history in the US, and persons receiving disability benefits may be eligible right away.

8. After your Interview

(a) ***How soon will my application be approved or denied?***

- **Medical** – No later than 45 calendar days after the date of application

(b) ***If I disagree with the eligibility decision or benefit level, can I have fair hearing?***

Yes - If you don't agree with a decision we make about your case, you can ask for a fair hearing in person, by telephone 1-800-432-6217 or (505) 827-8164, or in writing within 90-days of the date that a notice has been sent informing you of any action that has been taken on your case. Please mail your request to the HSD Hearing's Bureau at PO Box 2348 Santa Fe, NM 87504. You have a right to look at your case file and any records HSD used to determine your eligibility before your hearing. You can ask a household member or someone else like a friend or relative to represent your household at the fair hearing. You also have the right to have an attorney or other legal representative at the hearing.

(c) ***From what date are my benefits calculated?***

- **Medical** – From the 1st day of the month you applied. You may be eligible for up to 3 prior months of Medicaid coverage.

(d) ***How will I get my benefits?***

- **Medical** - A Medicaid card will be mailed to you one working day after the date of approval.

(e) ***How long can I get benefits before I have to renew them?***

- **Medical** – Up to 12 months is typical

(f) ***Do I have to report changes?*** **Always report address changes** within 10 calendar days for all types of assistance programs.

- **Medical –** For adults, report all changes within 10 calendar days. For families with children and pregnant women, you only have to report address changes within 10 calendar days. All other changes will have to be reported the next time you renew your case.

9. Notice of Rights

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 federal and state agencies. All information will be used to determine eligibility and/or to provide services. (03/29/12)

CIVIL RIGHTS STATEMENT All programs administered by the Human Services Department (HSD) 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 New Mexico Human Services Department central office, ATTN: Quality Improvement Section, Pollon Plaza, P. O. Box 2348, Santa Fe, New Mexico 87504-2348 or the local Human Services county office. Complaints of discrimination about the Supplemental Nutrition Assistance Program may be filed with the USDA, Director, Office of Adjudication, 1400 Independence Ave, S.W. Washington, DC 20250-9410 or call 1-866-632-9992 or 202-401-0216 (TDD). Complaints of discrimination about Medical Assistance programs may be filed with the Office of Civil Rights, Department of Health & Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202 or call 1-800-368-1019 (voice) and 1-214-767-8940 (TDD). (08/16/11)

YOUR RIGHT TO A HEARING - 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. You can ask for an HSD hearing by:

- Completing and returning the bottom of a notice;
- Writing or calling your local HSD office; or

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- Writing the department's Hearings Bureau at Human Services Department, P.O. Box 2348, Santa Fe, N.M. 87504-2348, or by calling 1-800-432-6217 (press 6) or 505-476-6213. (Revised 08/16/11)
- Marketplace HEARING - I know that if I believe the Marketplace has made a mistake about my eligibility, I may appeal the action by contacting the Health Insurance Exchange at 1-800-318-2596 and properly inform it that I believe their action should be reviewed. I know I may authorize someone else to represent me in the appeals process.

TIME LIMIT FOR ASKING FOR A HEARING - You have 90 days from the date of this notice to ask for a hearing. If you ask for a hearing within 13 days from the date of this notice, you will continue to get the same amount of benefits you received before we took the action in this notice. You will continue to get these benefits until the Department decides your case, unless another change is made to 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 the Department decided your case. (Revised 9/24/02)

THE HEARING PROCESS - After you ask for a hearing, the Department or the Marketplace will send you a letter telling you the date, time and place where your hearing will be held. The hearing is usually at the HSD county office. The hearing will be conducted by a hearing officer from the HSD Hearings Bureau or the Marketplace. You or your representative can look at your case record and any proof we used to decide your case. You will tell why you believe HSD's or Marketplace action was wrong. You may bring witnesses and present proof. You may question the county office or the Marketplace about the action taken and proof presented. You may represent yourself. 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 Marketplace Executive Director will decide whether the action was right or wrong. After the Director has decided your case, you will be sent a letter telling you of the decision and why the decision was made. (Revised 04/02/03)

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Employer Coverage Form

Applying for help with health insurance costs from the Health Insurance marketplace?

The Health Insurance Marketplace 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.

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 a Health Insurance Marketplace application.

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.

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

What's 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_____

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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	Site Code

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

POLITICAL PARTY			DAY TIME TELEPHONE NUMBER (Optional)		POLL WORKER
5	NOTE: You must name a major political party to vote in primary elections. ➡ ➡ ➡	Party	If you choose NO PARTY, Check this box ❑	6 May the County Clerk make this telephone number public for election purposes? ❑ Yes ❑ No	Would you like to serve as an election day precinct worker? ❑ Yes

7	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:		ATTESTATION OF QUALIFICATION
8	Are you a citizen of the United States? ..... ❑ Yes ❑ No Will you be 18 years of age on or before election day? ..... ❑ 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 _____/_____/_____	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 the 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 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 the information I have provided is correct. ➡ SIGN YOUR FULL NAME OR MARK ON THE LINE BELOW:
9	Name of agent who assisted you in filling out this form.	VRA ID #

DO NOT WRITE IN SHADDED AREAS – FOR OFFICIAL USE ONLY										
Accepted for filing in County Registration Records: _____/_____/_____ Date County Clerk Filing Clerk	ID SCHOOL	PCT	MUN CC	PRG DIST	REP	DIST SEN	DIST			

Registrarse para Votar

HSD Site Code I-

NMVR-1 HSD (2012)

INFORMACION PERSONAL					Esta información no se debe copia	
1	NOMBRE: Apellido	Su Nombre de Pila	Otro Nombre o Inicial	Género	Fechade Nacimiento	Número de Seguro Social

DIRECCION DONDE UD. VIVE AHORA				
2	Número y Nombre de la Calle	Departamento, Unidad o # de Lote	Ciudad	Zona Postal

DIRECCION DONDE UD. RECIBE SU CORRESPONDENCIA				
3	Dirección	Ciudad	Zona Postal	Site Code

4	¿Si Ud. Va cambier su nombre en esta solicitud, bajo que nombre completo estaba Ud. Matriculado antes?	Apellido	Nombre de Pila	Otro Nombre o Inicial

PARTIDO POLITICO		NUMERO DE TELEFONO EN EL DIA (Opcional)		EMPLEADO / A EN URNA ELECTORAL
5	AVISO: Ud. tiene que indicar partido politico principal para votar en la elección primaria ➡ ➡ ➡ Partido	Si Ud. NO ELIGE Partido marque aquí ❑	6 ¿Con motivo del elecciones puede divulgar el escribano de Condado esté núm. De teléfono? ❑ Si ❑ No	¿Quiere Ud. trabajar en recinto electoral el dia de la elección? ❑ Si

7	Por la presente autorizo que Ud. cancele mi matrícula previa en el condado y estado a continuación.	Ciudad o División	Condado	Estado

Favor de contestar las preguntas a continuación:		TESTIMONIO DE CALIFICACION
8	¿Es Ud. ciudadano / a de los Estados Unidos? ..... ❑ Si ❑ No ¿Habrá cumplido Ud. 18 años en o antes del dia de la elección? ❑ Si ❑ No Si Ud. marcó "NO" en cualquiera de las preguntas más arriba no termine de rellenar este formulario. Si usted fue condenado de un delito grave y actualmente esta en libertad condicional o probación supervisada, no llene esta forma. ➡ FECHA: Mes Dia Año _____/_____/_____	Yo juro/afirmo que soy ciudadano de los Estados Unidos y residente del Estado de Nuevo México; que la corte no me ha denegado el derecho de votar por motivo de incapacidad psicológica; que tengo o tendré 18 años de edad en la fecha de la próxima elección y si he sido condenado de delito grave he cumplido todas las condiciones de libertad a prueba o el gobernador me ha concedido indulto. Ademas, juro o afirmo que autorizo la cancelación de toda matrícula anterior con el fin de votar en el territorio de mi residencia previa; y que la informacion proveido esta correcto. ➡ FIRME SU NOMBRE COMPLETO O MARQUE LA LÍNEA ABAJO:
9	Nombre de la persona que le ayudó a llenar este formulario:	VRA ID #

NO ESCRIBA EN LOS ESPACIOS EN COLOR GRIS – SOLO PARA USO OFICIAL										
Accepted for filing in County Registration Records _____/_____/_____ Date County Clerk Filing Clerk	ID SCHOOL	PCT	MUN CC	PRG DIST	REP	DIST SEN	DIST			

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