MEDICAID APPLICATION FOR WOMEN, CHILDREN, AND FAMILIES

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

Programs of Medical Assistance

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

There are other Medicaid programs that require an application different from this one.

Federal regulations require that all individuals receiving Medical Assistance provide specific documents that verify Citizenship or Legal Permanent Status and Identity. <u>This is a one time process.</u> *A U. S. birth certificate is the easiest way to establish proof of citizenship (other types of proof are listed below).*

For individuals born in New Mexico every effort will be made to help you verify your birth certificate through the New Mexico Department of Health. We will provide you information necessary to obtain birth certificates for those household members born outside of the state of New Mexico.

	Remember to provide proof of the following with your application: ▼	**One or more of the following may be used as proof…** ▼
☑	Identity	Copy of driver's license, Government ID with photo, INS letter or immigration card
☑	U.S. Citizenship	Copy of U.S. passport, Certificate of Naturalization, Certificate of Citizenship, U. S. Birth certificate, certification of birth issued by the Department of State, Certificate of Indian Blood. Do not send your Social Security Card.
☑	Legal Immigrant Status	Copies of Immigration card, or INS or Department of Homeland Security letter
☑	Income (for you and your spouse)	Current check stubs or Copies of Paychecks for the past 30 days *or* letter from your employer Copy of your check or award letter from Social Security, Veteran's, Retirement, or other sources Self-employment records such as Income Tax forms or Personal Wage Records
☑	Health Insurance (only for JUL or CHIP)	Copies of ID Card or Letter from your Health Insurance Company
☑	Pregnancy Due Date (if it applies to you)	Medical Statement of Due Date

ISD Office Use Only	Status ❑ Application ❑ Redetermination	Former Recipient ❑ Yes ❑ No	Cat.	Application Date	Date Mailed	Date Received
PE/MOSAA Use Only	PE Interviewer Name	PE Interviewer's Site		PE Interviewer Phone		Date Mailed to ISD Office

MAD 023 Revised 12/09

Applicant Information	
How do I apply for assistance?	1. Complete this application. 2. Bring or mail this application to the ISD office serving your area. 3. Provide needed items to help you qualify for the programs. 4. If the documents are incomplete, you will be asked to provide the needed information. 5. A decision on your application will be made within 45 days, unless you ask for more time to get information. 6. You will be sent a letter about your application.
Fair Hearings	You may request a fair hearing, by telephone, in person, or in writing, within 90 days of the date the decision was made on your case. You may have another person represent you. If you do not agree with a decision made on any matter concerning your case, you have the right to look at your case record and other documents used to decide your case before the hearing.
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. Complaints of discrimination about the *SNAP* program may be filed with the USDA, Director, Office of Civil Rights Room 326 W, Whitten Bldg., 1400 Independence Ave, S.W. Washington, DC 20250-9410 or call (202) 720-5964 (voice and 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 (800) 368-1019 (voice) and (214) 767-8940 (TDD). (09/02/09)
Responsibility to Report Changes	The information I give during the application process is used to determine eligibility. It is my responsibility to report **only** changes that would result in a loss of eligibility. This includes increase in income above the program limits, persons living with me, moving out of state, and in some cases other health insurance.
Assignment of Rights to Payment	I understand that by getting **JUL or CHIP** Medicaid benefits for myself and/or other persons, I automatically give HSD all rights to medical support and to payment for medical care from a third party. A third party can include an absent parent, an insurance company, or another person who must pay for medical care and services. I understand that I must help HSD: ▪ Identify the father of a child who gets Medicaid. ▪ Identify any third parties who may have to pay for medical care and services. I understand that if I do not help HSD, I may not get Medicaid benefits or may lose my benefits, unless I can show a good reason for not helping HSD.
Confidentiality	I understand that all information I give to HSD is confidential. Information will only be used for eligibility purposes or to provide services. By law, confidential information may be released to other agencies that manage federal programs.
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. 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 your household, 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 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.

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.

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	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

2. Tell us about the people you are applying for

Please fill in the spaces below for everyone who lives in your home. If you need more space, attach a separate piece of paper.
Provide Social Security Numbers and Citizenship **ONLY** for those who are applying for assistance.

List names and information for yourself and all the people who live with you:					Fill out this section <u>only</u> for each person applying			
Name (First and Last)	**Relationship**	**Sex M/F**	**Date of Birth**	**Race & Ethnicity** (Optional)	**State & County of Birth**	**Maiden Name of Mother of Each Applicant**	**Citizenship *** see list below	**SSN #**
1.	(Self)							
2.								
3.								
4.								
5.								
6.								
7.								
8.								

► **Citizenship List:** Choose the best citizenship type below for each person applying for assistance and write the number above.

1. U.S Citizen
2. Lawful Perm Resident (LPR)
3. Refugee
4. Asylee
5. Cuban Haitian Entrants
6. Amerasians
7. Paroled to U.S. – 1 year
8. Withholding of Deportation
9. Battered Woman/Child
10. Active Duty Military
11. Hmong or Lao Tribe
12. Canada/Mexico American Indian
13. Other

Please answer the following questions about the people you listed in the above.

1. Is anyone in the household pregnant? Who?______________________________ Due Date ______________ ❑ Yes ❑ No
2. Has anyone in the household received medical services within the last 3 months which have not been paid? If yes, please list the members who have the bills and for which months. ❑ Yes ❑ No

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3. Does anyone in your household have health insurance? ❑ Yes ❑ No
4. Has insurance for a child or children been dropped in the last 6 months? If yes, provide name(s) of child(ren) and date(s) the insurance was dropped: ❑ Yes ❑ No

a.______________________________; b.______________________________; c.___________________________

Provide reason insurance was dropped:____

3. Tells us About Your Income

Have you or has anyone living with you received income or expect to receive income this month? ❑ Yes ❑ No
If yes, please complete the chart below.

Person with income	Income from?	$ Monthly Amount (Before Tax Deductions)	How Often Received? (Monthly, Biweekly, Weekly, etc)
		$	
		$	
		$	

Have you paid Dependent Care for a child this month? If yes, list the members and the amount paid per month?- ❑ Yes ❑ No

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Amount paid per month: $____

Do you get help paying for Dependent Care? ❑ Yes ❑ No

4. 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) that are not living with you:

Child Name	Absent Parent Name

5. 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 BELIVE 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).**

6. Your Signature (Your authorized representative may also sign here)

BY SIGNING THIS APPLICATION, I AGREE TO THE FOLLOWING:

- To provide all information and proof needed to determine eligibility.
- To provide a Social Security Number for every household member who is applying for benefits.
- To permit the Human Services Department (HSD) to contact persons or agencies to verify needed information if I am not able to provide the information.
- To allow all information I give to HSD to be matched by computer with other federal, state, and local agencies.
- To allow HSD to examine medical records needed for eligibility decisions and/or for payment of benefits.
- I am declaring the identity of my children under age 16.
- If I knowingly give false, incorrect or incomplete information, I may be prosecuted for that crime.
- I understand that I must pay back any benefits that I am not eligible to receive.
- HSD will use the information I give to decide on my eligibility, so the information must be as correct as possible.

► Sign Here ✕ ______________________________ Today's Date ____________