MEDICAID APPLICATION FOR WOMEN, CHILDREN, AND FAMILIES

INFORMATION FOR THE APPLICANT

Please complete all the spaces on the application about you and your household members. If more space is needed to answer any of the questions on this application, you may use another sheet. Return the application to the local Income Support Division (ISD) office or to the person who is determining your temporary Medicaid eligibility.

This is an application for the four Medicaid programs listed below. There are other Medicaid programs that require an application different from this one.

To qualify for Medicaid, your household must meet certain guidelines. You may be eligible for benefits for up to three months before your application date. You may ask about these guidelines by contacting the ISD office, or by calling toll free 1-888-997-2583.

- **JUL 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, and **receiving Medicaid benefits will not count toward the cash assistance time limit.**
- **MEDICAID FOR CHILDREN** provides coverage for children under age 19. Some children may be eligible under the State Children's Health Insurance Program (SCHIP). SCHIP children have small co-payment requirements. Native American children who are eligible for SCHIP do not make co-payments.
- **MEDICAID FOR PREGNANCY-RELATED SERVICES ONLY** covers only those services that are related to the pregnancy. Coverage for these services are provided for up to two months after the month in which the child is born or the pregnancy ends.
- **MEDICAID FOR FAMILY PLANNING SERVICES** covers only those services that are related to family planning for women of child-bearing age.

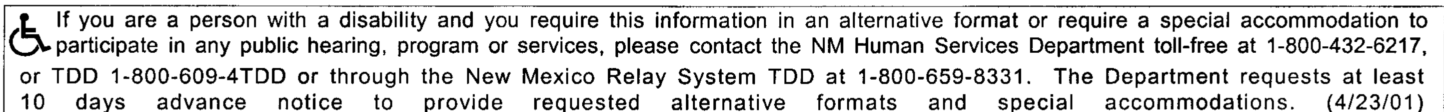
You need to provide proof of the following:

- Income for the past four weeks.
- Social Security Number (SSN), or proof of application for SSN.
- Children's ages.
- Other health insurance, if any.
- Pregnancy due date.

If you need help filling in this application or in getting the needed information, contact your local ISD office.

After your application is received, all documents will be reviewed. If the documents are incomplete, you will be asked to provide the needed information. A decision on your application will be made within 45 days, unless you ask for more time to get information. You will be sent a letter about your application.

APPLICANT: Please keep this sheet for your records.



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 TDD 1-800-609-4TDD or through the New Mexico Relay System TDD at 1-800-659-8331. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (4/23/01)

MY RIGHTS AND RESPONSIBILITIES
Read carefully before completing the application.

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.**

HSD will use the information I give to decide on my eligibility, so the information must be as correct as possible.

If the information I report is false, incorrect, or incomplete, my benefits may be denied or ended.

- **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 I am not eligible to receive.**

FAIR HEARING RIGHTS - I understand I may request a fair hearing, either by telephone, in person, or in writing, within 90 days of the date the decision was made on my case. I may have another person represent me. I understand that if I do not agree with any decision made on any matter concerning my case, I have the right to look at my case record and other documents used to decide my case before the hearing.

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 agencies managing federal or federally funded programs. All information will be used to determine eligibility and/or to provide services.

RESPONSIBILITY TO REPORT CHANGES - The information I give during the application process is used to determine eligibility. It is my responsibility to report changes within ten (10) days of the date of the change or as otherwise required. This includes changes in address, income, resources, health insurance, and persons living with me.

ASSIGNMENT OF RIGHTS TO PAYMENT - I understand that by getting 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 and who was born outside of marriage, and
- 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.

RELEASE OF MEDICAL INFORMATION - By signing this application, I allow HSD to examine medical records needed for eligibility decisions and/or for payment of benefits.

CIVIL RIGHTS STATEMENT - All programs administered by HSD are equal opportunity programs. It is unlawful for HSD to discriminate against an applicant for or recipient of any program due to race, color, national origin, sex, age, religion, political beliefs, or disability. Complaints of discrimination may be filed with the New Mexico Human Services Department central office, the local Income Support Division County office, the U.S. Department of Health and Human Services, the U.S. Department of Justice, or the Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD).

☐ PE/MOSAA

AGENCY USE ONLY

Status ☐ Application ☐ Redetermination	Former Recipient ☐ Yes ☐ No	Cat.	Application Date	Date Mailed	Date Received
ISD Worker Number		Appointment Date			Time

HEAD OF THE HOUSEHOLD

NAME - *Last* *First* *Middle*	Home Telephone or Message Number
STREET ADDRESS - *Number / Street or Road / P.O. Box Number*	Work Telephone Number

City	State	Zip Code
MAILING ADDRESS - (if it is different from your home address)		
City	State	Zip Code

Have you ever used another name? ☐ Yes ☐ No If Yes, list other name(s) and date(s) they were used:

1. 2. 3.

HOUSEHOLD MEMBERS - List all children and other people living in the home. Answer all the questions for everyone listed.

NAME	Social Security Number*	Race	Sex M/F	Date of Birth			Relationship	U. S. Citizen*		Legal Alien*		Date of Entry Into U.S.*
				Mo.	Day	Yr.		Yes	No	Yes	No	
							SELF					

***This information is required only for those who are applying for Medicaid.**

MEDICAL NEEDS

Is anyone in the household pregnant? ☐ Yes ☐ No If Yes, who?____________________
Due Date: ____________________

Has anyone in the household received medical services within the last three (3) months which have not been paid?
☐ Yes ☐ No If Yes, Who has the unpaid bills and for which months? ____________________

HEALTH INSURANCE

Does anyone in your household have health insurance? ☐ Yes ☐ No If Yes, list person(s) below.
(MAD 009 must be completed)

1. 2. 3.

Has insurance for a child or children been dropped within the last six months? ☐ Yes ☐ No

If Yes, provide name(s) of child or children and date(s) the insurance was dropped:
1. 2. 3.

Explain why insurance was dropped: ____________________

INCOME – List all money received by people in your household. This includes: money from job training or work, self-employment, government benefits (SSA, VA, etc.), alimony, royalties, pensions, trusts, investments, property income, child support, unemployment, and any other earned or unearned money from any source.

Name of Person Receiving Money	Name of Employer, Person, or Agency Providing the Money	How Often is the Money Received?	Total Amount (before deductions)

DEPENDENT CARE

Do you pay anyone to care for a child or other household member, so you can work or train for a job? ❑ Yes ❑ No
Who is being cared for?

1. 2. 3.

Who Provides the Care?	Amount Paid	How Often is the Amount Paid?

COMPLETE THIS SECTION ALSO IF YOU ARE APPLYING FOR PRESUMPTIVE ELIGIBILITY.

Are you or your child(ren) receiving Medicaid now? ❑ Yes ❑ No
If Yes, tell the agency or doctor you or your child(ren) already have Medicaid and show your Medicaid card.

If you or a household member are pregnant, has presumptive eligibility been granted for this pregnancy? ❑ Yes ❑ No
If Yes, you are not eligible for presumptive eligibility for the remainder of this pregnancy.

Has your child(ren) received presumptive eligibility within the last six months? ❑ Yes ❑ No
If Yes, your child(ren) is not eligible for presumptive eligibility.

I have read all of the information in this application, or it has been read to me. This application is only for Medicaid.
I swear under penalty of law that the information I have given in this application is true, complete and correct to the best of my knowledge.
I give my permission to HSD to contact persons or agencies to obtain needed information about me.
I have been given my Medicaid rights and responsibilities.

Applicant's Signature Date

Signature of Person Who Helped Complete the Application *Witness (if applicant signed with an X)*

SOLICITUD DE *MEDICAID* PARA MUJERES, NIÑOS Y FAMILIAS

INFORMACIÓN PARA LA PERSONA QUE SOLICITA - favor de rellenar todos los espacios en blanco en la solicitud respecto a Ud. y las personas que viven en su hogar. Si necesita más espacio para responder a cualquiera de las preguntas, use una hoja de papel. Devuelva la solicitud a la Oficina Local de Asistencia Económica (*Income Support Division*) (*ISD*) o a la persona que está a cargo de determinar si Ud. tiene derecho de recibir los beneficios temporales de *Medicaid*.

Esta es una solicitud para los cuatro programas de Medicaid indicados en la lista más abajo. Hay otros programas de *Medicaid* que requieren una solicitud distinta que no sea ésta.

Para que Ud. califique para recibir los beneficios de *Medicaid,* las personas que viven con Ud. en su hogar tienen que satisfacer ciertos requisitos que constan en las directivas. Ud. puede indagar acerca de esas directrices comunicándose con la oficina *ISD* o llame gratis al número 1-888-997-2583.

- ***JUL MEDICAID*** provee los beneficios de *Medicaid* a padres, madres o parientes que tienen niños menores de 19 años que dependen en alguna persona para que los sostenga, aún si la familia no califica para recibir asistencia en efectivo o no desea solicitar asistencia en efectivo. El programa de *Medicaid* está totalmente separado de la asistencia en efectivo, y los beneficios de *Medicaid* que la persona recibe no cuentan en el límite de tiempo de la asistancia que la persona recibe en efectivo.

- ***MEDICAID* PARA NIÑOS** facilita cobertura para los menores de 19 años. Algunos niños podrán tener derecho de recibir los beneficios conforme al Programa de Seguro de Salud para Niños (*State Children's Health Insurance Program (SCHIP).* Los niños que tienen el programa *SCHIP* tienen que satisfacer los co-pagos mínimos. Niños Nativo Americanos que reúnen los requisitos para la cobertura *SCHIP* no pagan los co-pagos.

- ***MEDICAID* SÓLO PARA SERVICIOS RELACIONADOS CON EL EMBARAZO** cubre únicamente los servicios relacionados con el embarazo. Este programa cubre estos servicios hasta por dos meses después del mes en que la madre da a luz o cuando termina el embarazo.

- ***MEDICAID* PARA SERVICIOS DE PLANIFICACIÓN FAMILIAR** cubre únicamente los servicios relacionados con la planificación familiar para mujeres de edad en que pueden dar a luz.

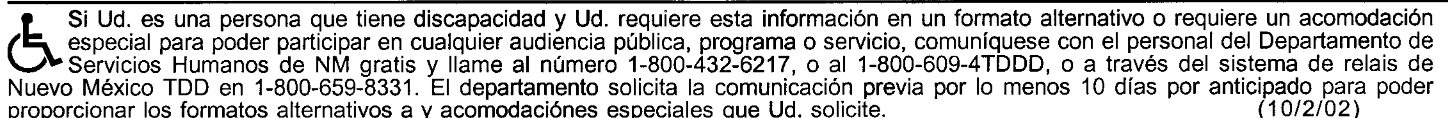
Ud. tiene que proveer las siguientes pruebas:

- Sus ingresos durante las últimas cuatro semanas.
- El Número de su Seguro Social (NSS) o prueba que Ud. ha solicitado su número de seguro social.
- Las edades de sus niños.
- Otro seguro de salud que Ud. tenga, si tiene otro seguro de salud.
- La fecha que Ud. va a dar a luz.

Si Ud. necesita ayuda para rellenar esta solicitud o para obtener la información que Ud. necesita, comuníquese con la oficina de *ISD*.

Después de que recibamos su solicitud, reexaminaremos todos los documentos. Si los documentos no están completos, le pediremos que nos facilite la información necesaria. La decisión con base en su solicitud se tomará dentro de 45 días, salvo que Ud. pida más tiempo para obtener información. Le enviaremos carta tocante a su solicitud.

SOLICITANTE: Favor de guardar esta hoja para su expediente.



Si Ud. es una persona que tiene discapacidad y Ud. requiere esta información en un formato alternativo o requiere un acomodación especial para poder participar en cualquier audiencia pública, programa o servicio, comuníquese con el personal del Departamento de Servicios Humanos de NM gratis y llame al número 1-800-432-6217, o al 1-800-609-4TDDD, o a través del sistema de relais de Nuevo México TDD en 1-800-659-8331. El departamento solicita la comunicación previa por lo menos 10 días por anticipado para poder proporcionar los formatos alternativos a y acomodaciónes especiales que Ud. solicite. (10/2/02)

MADSP 048 Reexaminado 11/12/04 *(Replaces MAD 048 & MAD 050) (SEE: MAD 023 English)*