Information Sheet for Medicaid Application for Assistance

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

- 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

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
		( )
		( )

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:____________________

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 on Page 16.
				$	
				$	
				$	
				$	

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. ❑ Yes ❑ No

a.______________________________; b.______________________________; c.__________________________

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)**	❑ **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 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 Molina:_______________________________
❑ **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.

Question	Answer
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?

Source	Answer
Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?	❑ Yes ❑ No
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
Money from selling things that have cultural significance?	❑ Yes ❑ No

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.
- 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 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: 1-800-477-3632).**

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.

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
- 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)

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__________

Register to Vote

	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	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:

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 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

ISDB 720 Issued 3/5/12