Susana Martinez, Governor
Brent Earnest, Secretary
Marilyn Martinez, Director

Manual Revision Memorandum

ISD-MR 15-26

TO: **ISD Employees**

FROM: **Marilyn Martinez, Director, Income Support Division**

DATE: **December 31, 2015**

RE: **Forms Manual Revision for: HSD 100 "New Mexico Streamlined Application for Assistance"**

Form FSP 100 "New Mexico Streamlined Application for Assistance" has been updated and revised to include questions for SNAP expedited screening; expanded immigration status types, and additional questions for immigration document numbers to assist with SAVE verification.

Instruction:

Delete: HSD 100 "New Mexico Streamlined Application" Rev 9/13

Replace: HSD 100 "New Mexico Streamlined Application" Rev 12/29/15

This form has been posted to the forms drive:**disfasv025\ISDForms**

If you have questions regarding this MR, please contact Marisa Vigil at (505) 827-1326 or by e-mail at Marisa.Vigil@state.nm.us.

Attachment: FSP 300 SNAP Medical & Caretaker Exemption Form

Information Sheet for Application for Assistance

Human Services Department benefits:

Medicaid: Provides health care for individuals and families with low incomes and resources. Depending on the income and resources in the household, household members may qualify for full or limited Medicaid Coverage. To apply by phone please call 1-855-637-6574.

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

Or

Send your signed application to your local Income Support Division (ISD) office or mail it to:

Central ASPEN Scanning Area (CASA)
PO BOX 830
Bernalillo, NM 87004
or Fax to 1-855-804-8960

New Mexico Health Insurance Marketplace (NMHIX)

- The NMHIX 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).
- Tax subsidies that can immediately help pay your premiums for health coverage may be available.

To apply for health insurance online through the NMHIX, you can go to:

www.bewellnm.com

Or

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

<table>
<tr><th colspan="3">Assistance Programs</th></tr>
<tr><td rowspan="6">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.)</td><td colspan="2">Depending on the income and resources in the household, household members may qualify for full or limited Medicaid Coverage. The following are types of Medicaid that household member may qualify for:</td></tr>
<tr><td colspan="2">Complete Sections 1-9 & 16</td></tr>
<tr><td>• Newborns
• Children up to age 18
• Parent(s)/Caretaker(s)</td><td>• Pregnant women
• Low-income adults
• Emergency Medical Services for Aliens</td></tr>
<tr><td colspan="2">Complete Sections 1-9,12-13 & 16</td></tr>
<tr><td>• Aged, blind and disabled individuals
• Working Disabled Individual</td><td>• Institutional care
• Home and Community Based Services Waiver</td></tr>
<tr><td colspan="2">NM HEALTH INSURANCE MARKETPLACE
The NMHIX is a way to shop for and compare health insurance plans for individuals and families who are not eligible for Medicaid. If you do not qualify for Medicaid, you or members of your household may be eligible to receive a tax subsidy that can immediately help pay for health insurance premiums. If you or members of your household do not qualify for Medicaid, your application will be automatically sent to the NMHIX, where you or members of your household may be found eligible for other health insurance affordability programs.</td></tr>
<tr><td>MEDICARE SAVINGS PROGRAM</td><td colspan="2">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 1-9,12-13 & 16</td></tr>
<tr><td>SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)</td><td colspan="2">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 -7, 11 - 13, 15 & 16 so ISD can determine benefits faster.</td></tr>
<tr><td>CASH ASSISTANCE</td><td colspan="2">Temporary Assistance for Needy Families (TANF) 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 -7, 10-13, 15 & 16</td></tr>
<tr><td>Low Income Home Energy Assistance Program (LIHEAP)</td><td colspan="2">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 -7, 14 & 16</td></tr>
</table>

You have the right to file your application today, please do not delay.

SNAP/FOOD benefits start from the date you apply. Adults not seeking benefits can apply for other household members.

To begin the process, you only need to fill out section 1 and sign; ISD encourages you to fill out a complete application for faster benefit determination. You can bring, mail or e- fax (1-855-804-8960) the application to ISD.

Check the Programs You Want to Apply For ▶ ☐ SNAP/Food ☐ Medical Assistance ☐ Cash ☐ LIHEAP

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

▶ **Do you prefer a telephone interview?** Tell us why, please check one:

☐ I am disabled. ☐ Illness
☐ Age 60+ ☐ Working 20 or more hours/week ☐ Caring for a child under age 6 ☐ Caring for others
☐ Live too far from office ☐ I do not have transportation ☐ Bad weather ☐ Other:________________________

1. Tell Us About You:

If you need help filling out this application or 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	Date of Birth (optional)		Best Time to Contact You	
Street Address	City	County	State	Zip Code
E-mail Address	Telephone Number		Alternative Number (optional)	

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	

Expedited SNAP Screening (SNAP only) Fill this out if you are applying for SNAP to see if you can get SNAP benefits faster. **This is called expedited service. If you are eligible for Expedited SNAP, you must get SNAP within 7 days. If you are denied expedited service you have a right to an informal conference to be held within 48 hours of your denial. Ask to speak to a supervisor if you have questions.**

Question	Answer
1. Will your monthly income be LESS than $150 **and** money in the bank or cash be LESS than $100?	☐ YES ☐ NO
2. Will your monthly home and utility costs be MORE than your income, cash and money in the bank?	☐ YES ☐ NO
3. Is your household a migrant or seasonal farm worker household with very little money?	☐ YES ☐ NO

▶ **Sign Here ✕**__________________________ **Today's Date**______________________

Your signature is attesting to all information in section 16 of this application.

2. Person to Represent You (Authorized Representative or Guardian)

The authorized representative can be a person who helped you apply for and renew benefits or it can be a different person. If you want to have an authorized representative, you must tell us who that person is in writing.

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 assistance. An SSN is optional for people who are not applying for medical assistance, but providing an SSN can speed up the application process. You do not need to be a U.S. Citizen or file income taxes 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 information about their income 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. Racial and ethnic data on applicant households is voluntary; it will not affect your eligibility or the amount of benefits your household may receive. Native Americans are urged to identify themselves as such because Native Americans are entitled to certain special protections under the law. We ask everyone for racial and ethnic information to assure that benefits are distributed without regard to race, color or national origin. If you need more space, please use an additional sheet of paper. 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 the people who live with you. If you are applying for medical assistance, please include anyone who you will include on your federal income tax return:

This section is only required for each person applying for assistance.

Name (First and Last)	Relationship	Applying for Assistance? Yes/No	Sex M/F	Date of Birth	Ethnicity: Hispanic Y/N (Optional)	Race: 1-5 (See below) (Optional)	Tribal Affiliation	Social Security Number (SSN) – required **only if you have one** (optional for non-applicants)	Citizenship Immigration Status 1-22 (see below)
1.	(Self)								
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Race: For each person applying for help, choose from the numbers below that best describes their Race and write the numbers above.

1 - American Indian Alaskan Native	2 – Asian	3 – Black or African American	4 – Native Hawaiian or Pacific Islander	5 – White	6 - Other

Citizenship/Immigration Status: For each person applying for help, choose from the numbers below that best describes their U.S Citizenship or Immigration Status and write the numbers above.

1 – U.S. Citizen	2 – Lawful Permanent Resident (LPR)	3 – Lawful Temporary Resident (LTR)	4 – Asylee	5 – Refugee	6 Cuban/Haitian Entrant
7 – Paroled into the U.S.	8 – Conditional entrant granted before 1980	9 – Battered spouse, parent or child	10 – Victim of trafficking and spouse, child, sibling, parent	11 - Individual with non-immigrant status (includes individuals with visas, and citizens of Micronesia, the Marshall Islands and Palau)	12- Granted or Applicant for Temporary Protected Status
13 – Deferred Enforced Departure	14 – Deferred Action Status	15 – Granted withholding of deportation or withholding of removal	16- Applicant for withholding of deportation or withholding of removal	17 – Applicant for special immigrant status with approved visa petition	18 – Applicant for adjustment to LPR status, with approved visa petition
19 – Applicant for Asylum	20 – Registry applicant with Employment Authorization Document (EAD)	21 –Order of Supervision (with EAD)	22 – Applicant for cancellation of removal or suspension of deportation (with EAD)	23 – Other/Unsure	

4. Tax Information *(Fill out this section if you applying for Medical Assistance/Medicaid)* **The Applicant can still get Medicaid if they don't file Federal taxes.**

Please give the following information for every household member applying for medical assistance, even if the tax payer or tax dependent is not in your home. You do not need to file income taxes to apply.

A Name	B Does this person plan to file a federal income tax return next year?	C Will this person file jointly with a spouse/partner?	D Does this person have any tax dependents?	E Is this person claimed as a tax dependent on someone else's tax return?	F How is this person related to the tax filer?
	❑ Yes ❑ No	❑ Yes ❑ No If **yes**, name of spouse or partner:	❑ Yes ❑ No If **yes**, name(s) of dependents:	❑ Yes ❑ No If **yes**, name of the tax filer:	
	❑ Yes ❑ No	❑ Yes ❑ No If **yes**, name of spouse or partner:	❑ Yes ❑ No If **yes**, name(s) of dependents:	❑ Yes ❑ No If **yes**, name of the tax filer:	
	❑ Yes ❑ No	❑ Yes ❑ No If **yes**, name of spouse or partner:	❑ Yes ❑ No If **yes**, name(s) of dependents:	❑ Yes ❑ No If **yes**, name of the tax filer:	

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

For household members <u>applying for benefits</u> who are not U.S. Citizens, please give information that appears on their immigration documents. This will be used to see who can get benefits. If you do not know the information below, show your immigration document to ISD. If you need more space please attach another piece of paper.

Name	Immigration Document Type	Alien or I-94 Number	Card or Passport Number	SEVIS ID or Expiration Date (optional)	Other (Category Code or Country of Issuance)	Lived in the US Since 1996?	Is this person a spouse or parent of a veteran or on active duty with the U.S. Military?
						❑ YES ❑ NO	❑ YES ❑ NO
						❑ YES ❑ NO	❑ YES ❑ NO
						❑ YES ❑ NO	❑ YES ❑ NO

Is any applicant getting benefits in another state?	❑ Yes ❑ No	If, **YES**, Who? Which State?
Is any household member age 21 or younger and a full time student?	❑ Yes ❑ No	If, **YES**, Who?
Is any applicant imprisoned (detained or jailed)?	❑ Yes ❑ No	If, **YES**, Who? Which facility? Date of imprisonment: Date of release
Is any applicant in the household receiving Supplemental Security Income (SSI)?	❑ Yes ❑ No	If, **YES**, Who?
Was any applicant ever in foster care?	❑ Yes ❑ No	If, **YES**, Who?
Is any applicant disabled?	❑ Yes ❑ No	If, **YES**, Who?
Is any applicant already in or going into a nursing home, hospital or treatment facility?	❑ Yes ❑ No	If, YES, Who?

What type of facility?

❑ Nursing Home/Nursing Facility ❑ Hospital ❑ Intermediate Care facility for the Mentally Retarded (ICFMR) ❑ PACE ❑ Other, where? ________________

Is any applicant pregnant?	❑ Yes ❑ No	If, **YES**, Who? Estimated Due Date(s), (if known): Number of babies expected from this pregnancy (if known):
Has any applicant received a Primary Freedom Of Choice letter for a Home and Community Based Services Waiver?	❑ Yes ❑ No	If, **YES**, Who?

6. Tell Us About Your Earned Income.

Please report your total income before taxes. **Note:** If you are applying for medical assistance and you are offered health insurance from any employer, please fill out the Employer Coverage form attached to this application. Failure to complete this form will not delay your application for assistance.

Have you or anyone living with you received earned income or expect to receive earned income this month? ❑ Yes ❑ No ❑ Don't Know

If **yes**, please complete the chart below.

Person with Income	Average Number of Hours Worked per Week?	Income from? (Work, self-employment, odd jobs, etc.)	How often does this person get income? (Yearly, Monthly, Biweekly, Weekly, etc.)	How much does this person receive?	Does this person have an employer that offers Health Insurance? If **yes**, fill out the Employer Coverage Form to find out if you can get health insurance through the New Mexico Health Insurance Exchange, if you are found ineligible for Medicaid. You are not required to complete this form for Medicaid.
				$	❑ Yes ❑ No

				$	❑ Yes ❑ No
				$	❑ Yes ❑ No

Are any of the following deducted from your earnings? *(Medicaid Only)*

❑ Alimony Paid Who? ________________How Much $________ How Often? ____________	❑ Student Loan Interest? Who? ___________ How Much $____________ How Often? ___________	❑ Other Type Who? ________________How Much $________ How Often? ____________
❑ Other Type Who? ________________How Much $________ How Often? ____________	❑ ❑ Other Type Who? ________________How Much $________ How Often? ____________	❑ Other Type Who? ________________How Much $________ How Often? ____________

Tell Us About Your Other Income:

Examples of unearned/other income include, but are not limited to: unemployment, Social Security, pensions, retirement, rental income, capital gains, royalties, financial gifts and gambling winnings/prizes.

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 income that changes from month to month? ❑ Yes ❑ No ❑ Don't know

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?

If yes, complete the information below.

Person with Income changes	What income changes?	When and why does it change?	Total Income this year	Total Income You Expect for Next Year

8. 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? ❑ Yes ❑ No

If **yes**, please fill out the chart below. We may be able to help pay these bills..

Name on Bill	Bill Months

Please list all public and private health insurance, including Medicare information, for you and all people living with you applying for Medicaid.

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

9. Managed Care Organization (MCO) (This section will ONLY apply if you are found to be eligible for Medicaid.)

If you are eligible for Medicaid, your services will be provided by one of the four MCOs listed below. You have a choice of which MCO will provide your services. If you do not choose an MCO, you will be automatically assigned to an MCO by the New Mexico Human Services Department. 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

If you are Native American, you are not required to choose an MCO. If you choose not to select an MCO, you will be automatically enrolled in fee-for-service (FFS) Medicaid. If you are in need of long-term care services or if you have Medicare, you will be required to choose an MCO.

I am a Native American ❑ YES ❑ NO
If **yes**, please fill out the Native American or Alaska Native section on the next page.

If **yes**, please tell us if you want to enroll in a managed care organization (MCO): ❑ YES ❑ NO
If you want to enroll in an MCO, please select an MCO below.

❑ **Blue Cross Community Centennial**
(866) 689-1523 www.bcbsnm.com/community -centennial

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 this MCO:

❑ **Molina Healthcare of New Mexico**
(800) 580-2811 www.molinahealthcare.com

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 this MCO:

❑ **Presbyterian Health Plan**
(888) 977-2333 www.phs.org

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 this MCO:

❑ **United Healthcare Community Plan**
(877) 236-0826 www.uhccommunityplan.com

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 this MCO:

Native American or Alaska Native

Native Americans 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. If you need more space please attach another piece of paper.

Is any applicant a member of a federally recognized tribe? To ensure that you are not automatically enrolled in an MCO, please provide your tribal affiliation. ❑ YES ❑ NO If **yes**, Who? ____________________ What Tribe? ________________	**Is any applicant receiving per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?** ❑ YES ❑ NO If **yes**, Who? ______________How Much? _________How Often? ________
Do any 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 **yes**, Who? ____________________ 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?	**Is any applicant receiving 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 Much? _________How Often? ________ **Is any applicant receiving money from selling things that have cultural significance?** ❑ Yes ❑ No If **yes**, Who? ______________How Much? _________How Often? ________

If you are <u>not</u> 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: 10 through 16
• NURSING HOME • MEDICARE SAVINGS PROGRAM • WAIVER SERVICES • WORKING DISABLED INDIVIDUAL	• SNAP • CASH ASSISTANCE • LIHEAP

10. Parents Not Living with Their Children *(Cash Assistance only)*

By accepting cash and medical assistance for your children, you assign (give) HSD rights to collect child and medical 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 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 Information		
	Name	Date of Birth	Last Known Address

11. School Attendance

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, checking account, savings account, trust(s), CD – Certificate of Deposit, royalties, life or burial insurance, stocks or bonds, retirement account, livestock, house/land - not occupying, or recreation vehicles.

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

Resource or Asset	Who owns it?	$ Value	Bank or Company Name, if applicable.
		$	
		$	
		$	
		$	

B. Did you or anyone living with you transfer anything of value to others in the last 5 years (60 months)? (Medicaid only) ❑ 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, HUD or other entity or person.

If you do not report any of the expenses listed below, you will not receive a deduction for those expenses. **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**

Child Care or Adult Dependent Care ▶	$	Mileage Round Trip for Dependent Care ▶	$
Who/what agency is getting paid the Child Care expenses? ______________________			
Medical Expenses for applicants who are Elderly/Disabled: Includes Medicare premiums ▶	$	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	☐ Rent Includes Utilities ☐ Rent Does Not Include 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:	

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

A. ▼LIHEAP Information ▼

Do you need LIHEAP for: Heating ❑ or Cooling ❑

Do you have an energy emergency? ❑ Yes ❑ No

If Yes, check any of the items listed below that apply to you today.

- ❒ Non-working furnace/boiler/heat system
- ❒ Out of fuel (propane, wood, pellets, coal, oil)
- ❒ Less than 10% fuel remaining (propane, wood, pellets, coal, oil)
- ❒ Need utility/fuel deposit
- ❒ Disconnected- your fuel supplier has ALREADY turned off your service
- ❒ Disconnection Notice- your fuel supplier has NOT turned off your services, But is warning you they will if not acted upon.

Is the energy emergency life threatening? ❑ Yes ❑ No

Select the type of LIHEAP assistance you want, choose one: ❑ Electric ❑ Propane ❑ Wood ❑ Natural Gas ❑ Pellets ❑ Coal ❑ Kerosene

Is this energy bill included in your rent? ❑ Yes ❑ No | Do you receive subsidized assistance for this energy bill? ❑ Yes ❑ No

Is this a shared meter? ❑ Yes ❑ No | Is this used for a business? ❑ Yes ❑ No

Utility Company Name: ______________________ | Account Number: ____________________ | Name on the Account: ____________________

Do you have any other energy usage than what you are requesting LIHEAP assistance with?

❑ Yes ❑ No, If No, please tell us why: ❑ You are Homeless ❑ You live in a rural area ❑ No Utilities available ❑ Other______________

B.	▼Please provide your energy usage information for your home ▼	
What is your primary heating source? Choose one: ❑ Same as above in Section 14A (Skip to Section 14C) ❑ Electric ❑ Propane ❑ Wood ❑ Natural Gas ❑ Pellets ❑ Coal ❑ Kerosene		
Is this a shared meter? ❑ Yes ❑ No	Is this used for a business? ❑ Yes ❑ No	Utility Company Name: ________________ Account Number: ______________________ Name on the Account: __________________

C.		
Do you have an account for electricity service? ❑ Yes ❑ No – If **yes**, please complete the section below. If your heating source in **Section B** is electric or you selected No above, **DO NOT** complete the section below		
Is this a shared meter? ❑ Yes ❑ No	Is this used for a business? ❑ Yes ❑ No	
Utility Company Name: ___________________________	Account Number:________________________________	Name on the Account: _________________________

15. Please Answer the Following Questions About the People Listed in Section 3 that are asking for benefits.					
Buy and prepare meals together? If no, who is separate? __________	❑ Yes ❑ No	Disqualified from an assistance program?	❑ Yes ❑ No	Worker(s) on strike or lockout?	❑ Yes ❑ No
Fleeing Felon(s)? If yes, Who? _________________	❑ Yes ❑ No	Voluntarily quit job(s) in the last 60 days? If yes, Who? _________________	❑ Yes ❑ No	In violation of probation or parole? If yes, Who? ________________	❑ Yes ❑ No
Living on a Native American Reservation? Name of Reservation? _______________	❑ Yes ❑ No	Getting help from the Food Distribution Program on Indian Reservation (FDPIR)?	❑ Yes ❑ No	Getting Tribal TANF or General Assistance?	❑ 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	Is anyone a veteran? If yes, Who? ________________	❑ Yes ❑ No
Paying room and board? If yes, Who? _________________	❑ Yes ❑ No				

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 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.
- I understand that by providing the account numbers for my household energy supplier(s) I am authorizing the energy provider(s) to provide details about the account and energy use to HSD for the purposes of eligibility and determination of this and future applications, benefit determination, and program evaluation and analysis.
- I understand that by providing application information I am authorizing HSD and its authorized agents to share and report the data provided against federal, state, county, energy provider, employer and landlord databases or records.
- I understand if eligible for energy assistance benefits, I may be referred to other residential energy programs.
- I understand the information collected on this form may be disclosed to energy programs operating under HSD. HSD may share and use information collected for purposes of referral, research, evaluation and analysis.
- I understand that my utility companies will not have control over the data disclosed pursuant to this consent, and will not be responsible for monitoring or taking steps to ensure that HSD maintains the confidentiality of the data or uses the data as authorized.
- 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) and 7 CFR 273.2(n).
- To **withdraw** your application for any program, initial the box of the program ► ☐ SNAP ☐ Medicaid ☐ Cash ☐ LIHEAP

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

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

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 Human Services Department, American Disabilities Act (ADA) coordinator at 1-505-827-7701 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. (Revised 09/10/15)

2. Your Civil Rights/ Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.
The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
(1) mail: U.S. Department of AgricultureOffice of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.
For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.
To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).
This institution is an equal opportunity provider. (10/14/2015)
To file a complaint through HSD of discrimination and/or rude treatment regarding a program receiving Federal or State financial assistance, a complaint form is available at the ISD office or you may write to: NM Human Services Department, ISD Civil Rights Director, P.O. Box 2348, Santa Fe, NM 87504-2348 or by fax (505) 827-7241.

3. Confidentiality

All information you give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which you 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. 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 a claim is established 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.

You only have to give U.S. Citizenship and SSNs for household members that you are applying for. You do not need to be a U.S. Citizen to apply. Receiving energy, medical or SNAP/ food assistance will not prevent you from becoming a lawful permanent resident or U.S. Citizen. Non-citizen immigrants who are not requesting assistance for themselves do not need to give immigration status information, SSNs or other similar proofs; however, they must give information about their income because part of their income and things they own may count towards the households eligibility for assistance Certain benefits may be available for people without a SSN; ask ISD. Immigration information will not be shared with any immigration enforcement agency.

HSD will 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. (9/10/2015)

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 Enforcement Division (CSED) 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, from 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+
- Working 20 or more hours/week
- Disability
- Illness
- Live too Far from Office
- Transportation
- Caring for a Child Under Age 6
- Caring for Others
- Bad Weather
- Other Hardships, please talk to ISD

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 should be ready to give as many facts about your case as you can. Please refer to the chart below 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. You will be given a list of everything you still need to give, along with a receipt for proof you provided. If you need help, it is the Department's responsibility to help you, providing you are cooperating.

Verification of:	SNAP/food	Medical			Cash	Energy/LIHEAP	Examples of Proof
		Family or Adult	Child Only	Elderly/Disabled			
▪ 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. Alternative Verification may be accepted; please talk to your caseworker.
▪ 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, it is the Department's responsibility to help you, providing you are cooperating.							
▪ 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							
▪ Heating/Cooling Costs						✓	

7. Non-Citizen Immigrant Eligibility

Many immigrants can get assistance residing in New Mexico. Some immigrants must have been in a certain status for 5 years before they can get assistance. There are many exceptions. Any lawfully residing child under the age of 21 or pregnant woman that all other requirements can get Medicaid right away. So can refugees, asylees, battered spouses and children, and many others. Some immigrants are eligible without a social security number. Even if you do not have an immigration status that qualifies you for Medicaid, you may be able to get Medicaid for emergencies. Ask a caseworker for more information. We keep your information private and only share information with other government agencies to see which programs you qualify for. Immigrants in one of the following statuses may be eligible for Medicaid or other assistance, if they meet other program requirements

1 – U.S. Citizen	2 – Lawful Permanent Resident (LPR)	3 – Lawful Temporary Resident	4 – Asylee or Applicant for Asylum	5 – Refugee
6 – Cuban/Haitian Entrant	7 – Conditional Entrant granted before 1980	8 – Battered spouse, parent or child	9 – Victim of trafficking and spouse, child, sibling, parent	10 – Non-Immigrant: work or student visa, citizens of Micronesia, Marshall Island, & Palau
11 – Granted or Applicant for Temporary Protected Status	12 – Deferred Enforced Departure	13 – Deferred Action Status	14 – Granted or Application for Withholding of deportation or removal	15 – Applicant for special immigrant status
16- Applicant for adjustment to LPR status, with approved visa petition	17 –Registry applicant with an Employment Authorization Document (EAD)	18 – Order of Supervision with EAD	19 - Applicant for cancellation of removal or suspension of deportation with EAD	20 – Other/Unsure

8. After You Submit Your application.

(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. If you do not get SNAP within 7 days, you have a right to ask for an informal conference to see why you were not given expedite food benefits.
- **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	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN
1	11	2	01	3	12	4	02	5	13	6	03	7	14	8	04	9	15	10	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
	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
	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
1	11	2	01	3	12	4	02	5	13	6	03	7	14	8	04	9	15	10	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
	91		81		92		82		93		83		94		84		95		85
11	16	12	06	13	17	14	07	15	18	16	08	17	19	18	09	19	10	20	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

(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;
  2. the change(s) will cause your benefits to increase;

  Other important changes that you need to tell us about:

  - Change of the address where you get your mail. We want to make sure your mail will reach you.
  - Changes to household size (if anyone moves in or out of your home)
  - Change of residency (if you or anyone in your household moves out of New Mexico).
  - Changes to monthly household expenses...
  - Changes to resources (such as bank accounts, property and life insurance).
  - You should report changes at any time during your certification period that might increase the amount of your benefits (like the birth of a child or losing income).

  - **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 an Employment and Training Program?

- **SNAP/food –**
- Some people who get SNAP benefits may be required to participate in a work activity to keep getting SNAP benefits. During your interview, an ISD worker will explain these requirements and what you must to do. You will also receive a notice that explains the requirements. Adults subject to these requirements must do one of the following:
  - Meet with the NM Works Program to complete an assessment and plan for participating in the Employment and Training program and then meet all program requirements. and
  - Provide ongoing documentation to ISD that you are completing the activity.
- Not all adults are subject to these requirements. If you have questions or think you have been incorrectly required to participate in a work program, please contact your local ISD office or you may call Customer Service at (800) 843-8303 or request a fair hearing.

When you meet the following situations, you may be excused:

▪ Caring for an incapacitated person	▪ Receiving Unemployment Compensation	▪ Physically or mentally unfit for employment	▪ Pregnant Women
▪ Student(s) enrolled at least part-time	▪ Complying with TANF/NMW Program	▪ Participating in a drug/alcohol treatment program	▪ Applying for SSI
▪ Residing in a tribe, pueblo and nation with an estimated employment-to-population ratio as a measure for insufficient job availability	▪ Persons younger than 16 years of age or a person 60 years of age or older ▪ Participating in the ABAWD 20 hour work requirement	▪ 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	▪ A parent or other household member responsible for the care of a dependent child under 13
▪ Employed at least 30 hrs./wk. or receiving weekly earnings = to the Federal min. wage x 30 hours	▪ A two year average unemployment rate 20% above the national average	▪ The cost of participating in the E&T program exceeds the out of pocket expenses	

- **SNAP/food** rules also state that certain able bodied adults who do not have dependents ages 18 to 49, who do not meet the previous situations are limited to 3 months of SNAP benefits unless you work, volunteer, and/or participate in certain employment and training programs. Please contact Customer Service at (800) 843-8303 if you think this applies to you.
- **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 able to receive different work activities or less hours if any of the following apply to you:

▪ Single Parent Caring for a Child under 12 Months Old – 1 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

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 our EBT contractor. 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 you order a new one, your old card will be deactivated. You will have to wait for your new card to arrive in the mail before you can access your benefits. When ordering a new card your PIN number will not change. You can change your PIN when your new card arrives by calling the EBT contractor at 1-800-843-8303.

(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 EBT contractor 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 EBT contractor 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 our EBT contractor. 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 EBT contractor 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 EBT contractor 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 the EBT contractor. 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, an EBT card that is 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. You must not use your SNAP/food assistance benefits to pay credit accounts.

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 under other federal and state laws containing criminal penalties.

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. Fair Hearing Rights

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. Any time you disagree with a decision taken on your case, you have the right to request a fair hearing with an official who is required by law to review the facts of every case in a fair and objective manner and give you a chance to explain why you do not agree.

In what situations can you ask for a fair hearing?

- You apply for benefits and are denied, or
- You disagree with a decision on your case, or
- You believe your benefits were not calculated correctly, or
- A change was made that you do not agree with.

By when must you ask for a fair hearing?

You have 90 days from the date of 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. You do not have a right to a fair hearing if the Department's decision which you are challenging was the result of a Federal or State mass change. (Revised 7/15/14)

How do you request a fair hearing?

- Complete and return the bottom of a notice, or
- Write or call your local HSD office, or Customer Service Center at 1-800-283-4465
- Write the Department's Fair Hearing's Bureau at HSD, P.O. Box 2348, Santa Fe, N.M. 87504-2348, or by calling 505-476-6213.
- If you disagree with the Federal Marketplace decision - If you believe the Marketplace has made a mistake about your eligibility, you may appeal the action by contacting the New Mexico Health Insurance Exchange at 1-800-318-2596 and properly inform it that you believe their action should be reviewed. You may authorize someone else to represent you in the appeals 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 Fair Hearings Bureau or the Marketplace. Prior to the hearing, you or your representative can look at your case record and any proof we will be using 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 (in English and Spanish). After the hearing, the hearing officer will make a report. The HSD Division Director or Marketplace Executive Director will decide whether the Department's 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 07/15/14)

Employer Coverage Form

Applying for help with health insurance costs from the NM Health Insurance marketplace? If yes, please complete this form.

Failure to complete this form will not delay your application for other benefits like food assistance, cash assistance or Medicaid.

The New Mexico 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 NM 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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Register to Vote

Protected: See Privacy Notice*

This information not to be copied.

PERSONAL INFORMATION

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

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

5 E-Mail Address (*optional)

POLITICAL PARTY

6 NOTE: You must name a major political party to vote in primary elections | Party | If you choose NO PARTY, check this box. ☐

DAYTIME TELEPHONE NUMBER (optional)

7 May the County Clerk make this telephone number public for election purposes? ☐ YES ☐ NO

POLL WORKER

Would you like to serve as an election day precinct worker? ☐ YES

8 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:

9 **Are you a citizen of the United States?** ☐ YES ☐ NO
Will you be 18 years of age on or before the next general election? ☐ 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 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 a 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 information I have provided is correct.

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

10 Name of agent who assisted you in filling out this form: | VRA ID #

SP&G-1 (2015)

DO NOT WRITE IN SHADED AREAS – FOR OFFICIAL USE ONLY

Accepted for filing in County Registration Records
____________ / ______________________ / ______________
Date County Clerk Filing Clerk

PCT.	MUN.	PRC DIST.	REP DIST.	SEN. DIST	SCHOOL	C.C.

IN ORDER TO PROCESS YOUR CERTIFICATE OF REGISTRATION YOU MUST COMPLETE THIS APPLICATION.

YOU WILL RECEIVE CONFIRMATION BY MAIL OF YOUR REGISTRATION FROM THE COUNTY CLERK.

*PRIVACY NOTICE

Your Social Security number and date of birth are required to register to vote. Pursuant to New Mexico law, the secretary of state, county clerk or any other registration official agent may not release to the public a voter's social security number or date of birth. A person who unlawfully copies, conveys, or uses information from a certificate of registration is guilty of a fourth degree felony. See NMSA, 1978 § 1-4-5 and NMSA, 1978, 1-4-5.4.

Per NMSA 1978 § 1-5-14(D) voter files provided to the publish shall not include email address.

USE THIS AREA ONLY IF YOU LIVE AT A RESIDENCE WITH NO PHYSICAL ADDRESS

If the address where you live ("Physical Address") is one of the following:

- a rural address
- a non-street address
- a non-traditional place

In the space provided to the right, you must draw a map of where you live in relation to local landmarks, such as roads, schools, churches, stores, etc.
This will help your county clerk to determine your correct voting precinct.

Also, in the space below "RURAL ADDRESS DESCRIPTION", please describe the following:

1. the actual number of the state or county road on which your residence is located, and on which side of the road it sits (east, west, north, south);
2. the number of the nearest state roads that cross your road (in both directions from either side of your home), or the names of the identifiable landmarks;
3. the distance and direction you would travel from home to reach these roads;
4. the distance you would travel to reach your home if you live on a private road that is an extension of a public road (please note at which end of the public road your road begins east, west, north or south.
   EXAMPLE RD 678, north side, 1 mile east of RD 615
   -OR-
   RD 73, west side, 1 mile north of Smith's store and 4 miles south of RD 698
5. any county issued rural address assigned to your physical residence where you live now:
   EXAMPLE 3251 CR W Grady, NM 88120
   This address may also be used in Block 2 "PHYSICAL ADDRESS WHERE YOU LIVE NOW" on the reverse of this form.

MAP

N
W + E
S

RURAL ADDRESS DESCRIPTION

ALL VOTER REGISTRATION FORMS MUST INCLUDE A MAILING ADDRESS IN BOX 2 OR BOX 3 ON THE REVERSE OF THIS FORM.