RIO ARRIBA COUNTY
HEALTH CARE ASSISTANCE PROGRAM

1122 Industrial Park Road, Espanola NM 87532

Phone # (505)753-2992 ext. 5389 Fax# (505)753-9397 Email: smvigil@rio-arriba.org

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**	**AGE:**
Address:			**DOS:**
Account #:	**Co-Pay Amt:**	**Deductible Amt:**	**Amount Paid:**
Employer:		**Spouse Employer:**	
Resident o f Rio Arriba County (90days or More) ☐ **Y** ☐ **N**		**US Citizen** ☐ **Y** ☐ **N**	

I hereby authorize the Espanola Hospital to release my Medical records to the Rio Arriba County Health Care Assistance Program.

Patient or Responsible Signature: **Date:**

Briefly explain as to the nature of this Medical Condition (Please enclose itemized statement)

Authorized Hospital Representative: **Date:**

Household Members		
Age	**Name** *(Last, First, M.I.):*	**Occupation**

Residence History		
From/To		**State**

LIST BELOW THE TOTAL FAMILY ANNUAL INCOME OF ALL THE MEMEBERS OVER 18 YEARS OF AGE		
Wages	Unemployment Comp	Military Family Allotment
Self Employ	Workman's Comp	Pensions
Public Assist.	Alimony	Dividends, Interest, Rent
Social Sec.	Child Support	Other Benefits
LIST BELOW, THE TOTAL FAMILY ASSESTS: $		
Checking Account	Real Estate Owned	
Savings Account	Automobile Owned	
Certificate of	Stocks & Bonds	
Deposit	Other	
LIST BELOW, YOUR TOTAL OBLIGATIONS: $		
Rent	Credit Card Payment	
House Payment	Finance Companies	
Car Payment	Stocks & Bonds	
Make & Model of Cars	Other	
Total Monthly Expenses	Subtract Expenses from Net take	

Insurance	Is this case covered by insurance? If yes list insurance name	☐ Yes	☐ No
	Is there any legal action pending of this case? I yes, please explain	☐ Yes	☐ No

I, the undersigned, hereby verify that I qualify or "HCAP" Assistance.

"Health Care Assistance" (means a person to whom a health care provider has provided medical care, and who can normally support him/herself and his dependents on present income and liquid assets available to him /her but, taking into consideration this income and those assets and his/her requirements for other necessities of life for himself/herself and himself/herself and his dependants, is unable to pay the cost of co-pays and deductibles. This definition also includes a minor who has received medical care and whose parent, or the person having custody, is normally able to support the minor on present income and liquid assets available, but taking into consideration this income and his assets and the requirements of necessities for himself/herself and for his/hers dependents is a person who cannot pay the co-pay and deductibles cost of the minors care.

I, the undersigned, hereby authorized the Espanola Hospital and the Rio Arriba County Health Care Assistance Program to make any inquiry of any person, firm or corporation relevant to this statement, further authorized any person, firm or corporation to provide pertinent information as may required by said hospital or board.

(This statement and all entries on it constitute an oath of the person signing it and false statement knowingly herein shall constitute a felony.)

Indigent Patient_____Date_____
Witness_____Witness_____

I_____being first duly sworn, on oath that I am a resident of Rio Arriba County and that I am without sufficient funds or sources of income to pay my account with Espanola Hospital in the amount of $_____or any part thereof. That I do not foresee any possibility of being able to pay the account at any time in the future.

Dated this_____day of _____,_____

_____
Indigent Patient

SUBSCRIBED TO AND SWORN TO, BEFORE THIS_____DAY OF_____,_____

_____
NOTARY PUBLIC