Sierra County Health Care Application

1.Patient/Paciente:

Last Name/*Appellido* First Name/*Nombre* Middle/*Segundo Nombre*

D.O.B./*Fecha de Nacumento*_____SSN/*No. Seguro Social*_____Martial Status/*Estado Civil*: M D W S

Mailing Address/*Direccion de Correspondencia*:_____

City/*Cudad*_____State/*Estado*:_____Zip Code/*Codigo Postal*_____Telephone_____

***Please Circle All That Apply

2. Resident Alien Status: U.S. Citizen/*Ciudadano de los Estados Unidos*, **Temporary**/*Residencia Temporal*, **Permanent**/*Residencia Permanente*—**Note**/*nota* **if none of the above applies to you provide INS documents verifying status/*si ninguno se aplica ha usted, consige los documentos de la Immigracion que esta en proteso*

3. Residency/Residencia:

List physical address/*Liste su residencia fisica*:_____

Do you/*Que Used*: **Rent**/*Renta,* **Own**/*Dueno*, **Shared rent with other members**/*Comparte con otros miembros del hogar*, **Supplied free of charge**/*Mantanimiento gratis*, **Homeless**/*Sin hogar*

List prior physical residence if less than (1) year at the current address/*Liste su residencia fisica si menos que (1) ano en la residencia ultima:*_____

Address City State

(2) Non-Related References/*(2) Referencies-NoRelacion*

1._____

2._____

Name/*Nombre* Mailing Address/*Direccion* Zip Code/*Codigal Postal* Telephone

4. List all members in the home.Lista todos los miembros del hogar

Full Name/*Nombre Complete* DOB/*Fecha de nacim* SSN/*Seguro Social* Relationship to patient

Attach a separate sheet for additional members living within the home/*Junta otra pagina para lister todos miembros del hogar*

5. Income/Ingreso:

Employer/*Empleador*:_____Gross Amt. Received $_____

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Unemployment/*Desempleo* $_____ Educational Assistance/*Ayuda de Educacion* $_____

Welfare/(aka TANF) $_____ Workmen's Comp/*Compensacion de Trabajo* $_____

Food Stamps/*Estanpillas de comida* $_____ General Assistance/*Asistencia General* $_____

SSA/SSI Benfits/*Beneficios de Seguro Social Suplementario* $_____ Pension/*Retiro* $_____

VA/*Beneficios Veteranos* $_____ Other Income not listed/*Otro ingreso no puesto* $_____

**If you are employed this year, provide current check stubs verifying type of income earned for all employed/*Si usted estuvo empleado en este ano traiga talones de cheque corriente para poder comprobar el tipo de ingreso que entra a la casa para el empleado(s*).

Did the patient/or head of household file a Federal/State Income Tax Return last year?/*? Usted complete formas de immpuestos sobre los ingresos el gobierno Federaly del Estado*? (please circle) **YES/*Si*, NO (Earned/or Unearned Income/*Ingresos Percibidos*)

***If you were exempt from filing provide proof/*Si usted esta exonerado traiga preuda*.

*****Please Circle all that Apply*****

6. Other Insurance or Liability/*Seguro de responsabilidad*

Reason for medical treatment?/*?Porque razon fue el tratamiento?*

Personal injury/*Dano personal*, **Motor vehicle accident**/*Accidente de automovil* (provide police report/*consige el reporte de policia*), **Work related injury**/*Dano en el trabajo*, **Illness**/*Enfermedad*, **Pregnancy**/*Embarazo*, **Other**/*Otra razon*—Explain/*Explique*:_____

Provider Name/*Proveedor Medico*:_____ Date of Service/*Fecha de Servivo*:_____

Are there any liability claims or legal action pending as a result of this hospitalization?/?Hay reclamos legales debido ha este servicio medico? **YES/Si No**

Explain:_____

7. Medical Coverage/*Cubertura medical*

Is there any medical coverage for the family?/*?Hay cubricion medica para la familia?* **YES/Si NO**

For the patient?/*?Para el paciente?* **YES/Si NO**

Name of the Insurance?(include copy of card)/*?Nombre de la clase de seguro? (Incluya una copia de su tarjeta)*

_____

Does the patient or any other member of the household have Medicaid/Medicare?/*?Hay cubricion medica para el paciente o otro miembro del hogar de Medicaid/Medicare?* **YES/Si NO**

8. Public Assistance/*Otro tipo de asistencia publica*

Has the patient or anyone else within the household recently applied for the following?/*?El paciente o otro miembro del hogar han aplicado para lo siguiente?* **SSI/SSA (Disability/Encapacitado) Welfare (aka TANF)**

Date Filed/*Fecha de registro*:_____

Person that applied/*Persona que aplico*:_____

Explain if necessary/*Explique la situacion*:_____

9. Assets/*Recursos o bienes* **(Give value) (Ponga El Valor)**

Provides ALL proof of any investments or other properties owned by the applicant/patient or house hold unit as follows/*Prueba de TODOS inversioes o propiedades propio para el aplicante/paciente o el establecimiento domestic*

Personal Home/*Casa propia(valor de su propiedad)* $_____

Escrow Account/*Cuenta en custodia de tercera persona* $_____

Equity/*Equidad* $_____

Stocks or bond/*Ostros inversiones* $_____

Checking Accounts/*Cuenta de cheque* $_____

Savings Account/*Cuenta de ahorro* $_____

Investment/*Inversiones* $_____

If the patient is deceased, was there a life insurance?/*?Si el paciente expiro usted recibio compensacion de segurp?* **YES/Si NO**

Full Value/*Valor Completo* $_____ (Explain how excess proceeds were spent on comments of this application/*Explique como uso los ganancias de exceso en el comentarios de esta application*)

Have you sold any property(s) in the past year?/*?Usted ha vendido propiedad enel ultimo ano?* **YES/Si NO**

Income from Sale/*Ingresos de venta* $_____

Verified Statement of qualification for Sierra County Health Care/*Verifcecion de Elegibilidad para recibir asistencia por El Cuidado de La Salud del Condado de Sierra.*

<**That I am patient or the person having custody of the patient who has completed this application and verified statement**/*Yo soy el paciente o la persona en custodia del paciente verificando la declaracion de esta application*.

<**That there is no insurance to cover other than what was stated on this application**/*Que no existe ningun tipo de seguro menos lo que fue indicado en esta application.*

<**That I will authorize the release of all medical records and/or financial records needed by the Sierra County Health Care that will be utilized in processing my claim**/*Que autorizo la relevacion de toda informacion medico financier para la evaluacion de este reclamo por El Cuidado de La Salad del Condado de Sierra.*

<**That I will authorize the contracted provider(s) and the Health Care Administrator to make any inquiry of any person, firm or corporation to provide pertinent financial and residential information as may be requested. I further agree to save and hold harmless any person, firm or corporation, including any financial institution or agency from any liability whatsoever for the release of information relevant to this statement and the investigation of the facts pertinent to this claim**/*Que autorizo que los proveedores medicos y el Administrador de la oficina del Cuidado de Salud pregurate a cualquier persona, firma, corporacion o instiucion financier o agencia para proveer informacion pertinete a financier o residencial como sea solicitado. Ademas, yo consiento en dejar libre deresponsablidad a cualquir persona, firma corporacion o instiicion financier por dar la informacion relacionada a esta declaracion y de la investigacion de la verdad pertinente a esta reclamo.*

<**That I do not have any unforeseen resources available for this service(s), however, if a lawsuit arises the resources will be applied to repay for this service(s) to the Sierra County Health Care**/*Que yo no tengo inesperdo recursos disponibles para este service(s) y de cualquir modo si el procedimiento consiste de un pletio se reembolsardn los fondos a la Oficina de El Cuidado de La Salud del Condado de Sierra, parcial o totalmente para el servicio(s) medico.*

<**That I, the patient or person applying on behalf declare the above to be true and correct under penalty that any false statements made knowingly shall constitute a felony**/*Que yo, el paciente o la persona en custodia declare que toda la informacion es cierta y de cualquier informacion falsa provista deliberadamente constituye un delito.*

I, the undersigned, hereby verify that I have read and understand the Health Care Application, and I do understand the following section of the Indigent Health Care Act:

"The payment of any claim to any hospital and/or ambulance on behalf of an Indigent Patient, creates a preferred claim in favor of the fund against the estate of the Indigent patient and a lien against all real property or interest in real property vested in or later acquired by the Indigent patient or any person or persons legally responsible for his debts for the amount of the payment made from the fund to the hospital and/or ambulance, without interest. Such claims shall be preferred over all claims except charges of the last sickness and funeral of the deceased and allowance made by the court for the maintenance of the widow and children, taxes, municipal levies, cost of administration and attorney's fee. Proceeds recovered from such claims shall be place into the fund."

Signature/Firma:_____ Date/Fecha:_____

State of New Mexico)
) SS.
County of Sierra)

The foregoing instrument was acknowledged before me this_____day of_____, 20____

By_____.

NOTARY PUBLIC_____ MY COMMISSION EXPIRES:_____

_____

Name of party completing form (if other than patient)