PATIENT REFERRAL TO AN OUT OF ROOSEVELT COUNTY HOSPITAL

PATIENT NAME: _____

ADDRESS OF PATIENT: _____

REFERRED TO: _____

DATE REFERRED: _____

TRANSFERRED BY AMBULANCE: YES _____ NO _____

REFERRING PHYSICIAN: _____

ADDRESS & PHONE NUMBER: _____

_____
PHYSICIAN SIGNATURE

_____
DATE

PATIENT INFORMATION RELEASE:

I authorize release of the above information to the Roosevelt County Indigent Claims Administrator as representative of the Roosevelt County Indigent Claims Fund. Said information may also be released to any hospital and/or ambulance service associated with this application. Such release is to assist in processing my application to said fund.

_____
Patient or Responsible Party

_____
Date

RESIDENCY

DATE:_____

I, _____ of _____

do verify that _____

has resided in Roosevelt County at, _____

for the 90 days preceding his/her stay at (Hospital/Ambulance)_____

_____

_____

Hospital Admission Date: _____

Ambulance Transportation Service Date: _____

SIGNED THIS ____ DAY OF _____, 2_____.

_____
SIGNATURE OF VERIFYING PERSON

Subscribed and sworn to before me this _____ day of _____, 2_____

_____
NOTARY PUBLIC

(S E A L)

My Commission Expires:

MEDICAL ASSISTANCE
(Human Services Department)

APPLICANT/PATIENT:_____

S.S.N. _____ D.O.B. _____

RESPONSIBLE PARTY: _____

S.S.N. _____

TYPE OF BENEFIT: **MEDICAL ASSISTANCE**

[ ] HAS MADE APPLICATION
MEDICAID #_____ EFFECTIVE DATE
[ ] PENDING- REASON:
[ ] REASON FOR DENIAL:_____
_____
_____
_____

[ ] IF NO APPLICATION HAS BEEN MADE, **PLEASE INDICATE IF APPLICANT IS ELIGIBLE**

_____
APPLICANT SIGNATURE

_____
DATE

INFORMATION VERIFIED BY: _____
Case Worker or Social Services Representative

Date: _____

****

I hereby authorize the New Mexico Department of Human Services Income Support Division to release the following information to the Indigent Claims Administrator for the Roosevelt County Indigent Hospital Claims Board and any hospital and/or ambulance service connected with this claim.

EMPLOYMENT VERIFICATION

I hereby authorize my employer _____ to release the following information to the Indigent Claims Administrator for the Roosevelt Indigent Hospital Claims Board, and hospital and/or ambulance provider connected with this claim.

Date Employed:_____

Salary Per Hour:_____

Hours Worked Per Week:_____

Gross Salary For Last 12 Months:_____

Do You Offer Group Medical Insurance?_____

Is Employee Enrolled?_____

Do you Offer Group Life Insurance?_____

Is Employee Enrolled?_____

Any other information concerning this employee that you feel would be pertinent to the request for County assistance for medical expenses:

_____

_____

_____
Employee

_____
Date

Information verified by:_____
Employer or his/her representative/title

Date:_____ Telephone Number:_____

SOCIAL SECURITY BENEFITS

Applicant:_____ S.S.N:_____

_____ _____

_____ _____

Social Security Administration Please Fill Out the Following:

Date Applied:

Type of Benefit and Total Amount Paid: SSI:_____

SS:_____

MEDICARE:_____

DATE APPROVED:_____

DATE DENIED:_____

REASON DENIED:

_____

_____

CASE PENDING:_____

HAS NOT MADE APPLICATION:_____

_____

APPLICANT

_____

DATE

INFORMATION VERIFIED BY:_____

Social Security Representative, Title

Date:_____ Telephone Number:_____

RENTAL INFORMATION

Date:_____ Applicant:_____

I hereby authorize my Landlord, _____ to release the following information to the Indigent Claims Administrator for the Roosevelt county Indigent hospital Claims Fund and any hospital or ambulance service connected with this claim.

LANDLORD PLEASE FILL OUT BELOW

ADDRESS:_____

DATE MOVED IN:_____

DATE MOVED OUT:_____

Any other information you might want to offer that you feel would be pertinent to this application for medical assistance:

_____

_____

_____ Date:_____

Landlord or Relative

Telephone Number:

****** **Note To Applicant** ******

If you have lived at several different places in the last four months, you must have a form filled out for each residence. If you are living with relatives, you must so state on the form and have the relative sign the form and supply a phone number.

_____ Date:_____

Applicant

Telephone Number:_____

VERIFICATION OF UNEMPLOYMENT BENEFITS

Vicki Aguilar
Roosevelt County Indigent
Claims Fund Administrator
Roosevelt County Courthouse
Room B-5
Portales, NM 88130

Phone Number (505) 359-0179

I hereby authorize the release of the requested information to the Indigent Claims Administrator for the Roosevelt County Indigent Claims Fund, and hospital and/or ambulance service connected with this claim.

NAME:_____ **S.S.N:**_____
DATE:_____

The above named person has submitted an indigent claim to Roosevelt County. I am required to verify income sources to determine the Applicant's eligibility for indigent funds, including any **UNEMPLOYMENT BENEFITS** that may have been applied for or received by the above-named applicant. Please complete this form and return it to me at the above address at your earliest convenience.

Thank you for your cooperation.

_____ ._____.
Applicant Date

****

To Be Completed By New Mexico Department Of Labor

Effective Date of Eligibility:_____

Benefits From:_____ To:_____ **Amount $**_____ [ ] Weekly

If Benefits were/are terminated, Date:_____

Total Earnings (Past Twelve Months) $_____

_____ _____
Signature/Title Date

Phone Number:_____

(HOUSEHOLD DEBTS/EXPENSES) excluding this claim

Debt/Expense	**Balance**	**Monthly**	**Debt/Expense**	**Balance**	**Monthly**
Rent/Mortgage			Dr.		
Gas, Water, Elec.			Dr.		
Auto Insurance			Telephone		
Health Insurance			Cable		
Home Insurance			Day Care		
Vehicle			Child Support		
Loan			Pharmacy		
Other			Other		