

## Information Sheet for Application for Assistance



### **Human Services Department (HSD) benefits:**

**Medicaid:** Provides free or low-cost health coverage for certain low-income individuals and families. Depending on your household income, some household members may qualify for full or limited Medicaid Coverage.

**Medicare Savings Program:** Provides help 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](http://www.yes.state.nm.us)

**Or take** your signed application to your local Income Support Division (ISD) office

**Or mail** your signed application to:

Central ASPEN Scanning Area (CASA)  
PO Box 830  
Bernalillo, NM 87004

**Or fax** your signed application to 1-855-804-8960

You can also apply for Medicaid over the phone by calling 1-800-283-4465



### **New Mexico Health Insurance Exchange (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 or your household may qualify for a program that can help you pay for a health insurance even if you earn as much as \$98,000 a year (for a family of four).
- Tax subsidies that can immediately help pay your premiums for health coverage may be available.

**You can apply for affordable health insurance online through the NMHIX at:**

[www.bewellnm.com](http://www.bewellnm.com)

**Or call** 1-855-996-6449  
TTY: 1-855-855-2018

## Assistance Programs

<b>Medical Assistance</b>	<p>Depending on your household income, some household members may qualify for full or limited Medicaid Coverage. The following are some types of Medicaid that household members may qualify for:</p>	
	<b>Complete Sections 1-9 &amp; 16</b>	
	<ul style="list-style-type: none"> <li>• Newborns</li> <li>• Children through age 18</li> <li>• Parent(s)/Caretaker(s)</li> </ul>	<ul style="list-style-type: none"> <li>• Pregnant women</li> <li>• Low-income adults</li> <li>• Emergency Medical Services for Non-Citizens (EMSNC)</li> </ul>
	<b>Complete Sections 1-9,12-13 &amp; 16</b>	
	<ul style="list-style-type: none"> <li>• Aged, blind and disabled individuals</li> <li>• Working Disabled Individuals</li> <li>• <b>Institutional Care:</b> Nursing Facility Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Program for All-inclusive Care for the Elderly (PACE)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Home and Community Based Services Waivers:</b> Community Benefit (CB) Waiver Developmental Disabilities Waiver (DDW) Medically Fragile Waiver (MFW) Mi Via Waiver (MVW) Supports Waiver (SW)</li> </ul>
<p><b>NM HEALTH INSURANCE EXCHANGE (NMHIX)</b> 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.</p>		
<b>Medicare Savings Program</b>	<p>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. <b>Complete Sections 1-9,12-13 &amp; 16</b></p>	
<b>Supplemental Nutrition Assistance Program (SNAP)</b>	<p>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. <b>Complete Sections 1-3, 5 -7, 11 - 13, 15 &amp; 16 so ISD can determine benefits faster.</b></p>	
<b>Cash Assistance</b>	<p>Temporary Assistance for Needy Families (TANF) provides cash assistance to families who qualify. <b>or</b> 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). <b>Complete Sections 1-3, 5 -7, 10-13, 15 &amp; 16</b></p>	
<b>Low Income Home Energy Assistance Program (LIHEAP)</b>	<p>The Low Income Home Energy Assistance Program (LIHEAP) assists eligible Low Income Families and Individuals with their heating and cooling costs. <b>Complete Sections 1-3, 5 -7, 14 &amp; 16</b></p>	

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

SNAP/Food benefits start from the date you apply. Adults who are not asking for benefits can apply for other household members. We will accept your application if it contains your name, address, and signature in Section One. This information will establish your application filing date. 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

▶ **Applications for SNAP and CASH Assistance require an interview. An interview is not required for most categories of Medical Assistance. If you are applying for a program that requires an interview, do you prefer a telephone interview?** Tell us why, please check one:

- I am disabled  Illness  Domestic Violence  Age 60+  Caring for a child under age 6  Caring for others  
 Live too far from office  Bad weather  I do not have transportation  Other reason: \_\_\_\_\_

**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 for SNAP and Cash)		Best Time to Contact You	
Street Address	City	County	State	Zip Code
E-mail Address	Telephone Number		Alternative Telephone 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you intend to remain in New Mexico? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you homeless? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you want to get your information sent to your e-mail? If YES, please fill out your most current e-mail address above.		<input type="checkbox"/> YES <input type="checkbox"/> 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 request for a conference. Ask to speak to a supervisor if you have questions.**

- |   |  |
|---|--|
| 1. Will your monthly income be <u>LESS</u> than \$150 <b>and</b> money in the bank or cash be <u>LESS</u> than \$100? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Will your monthly home and utility costs be <u>MORE</u> than your income, cash and money in the bank?              | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Is your household a migrant or seasonal farm worker household with very little money?                              | <input type="checkbox"/> YES <input type="checkbox"/> NO |

▶ **Sign Here X** \_\_\_\_\_ **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) Your authorized representative can be a person who has helped you apply for or 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, below.

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 Number or TDD
		( )

3. Tell us About the People Who Live with You and/or Individuals on Your Federal Income Tax Return.

Please list everyone who lives in your household, even if you do not want to apply for them. You only have to provide U.S. Citizenship and Social Security Numbers (SSNs) for household members who 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. Immigrant status of all individuals applying for benefits may be subject to verification by the Department of Homeland Security (DHS) through the submission of information provided on this application to DHS, and the information received from DHS may affect your household's eligibility and level of benefits. Non-citizen immigrants 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 household's eligibility for assistance. Certain programs may be available for people without an SSN; ask ISD. Racial and ethnic data about an applicant's household 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.

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:	Race:	Tribal Affiliation (Optional)	Social Security Number (SSN) – required if you have one (optional for non- applicants)	Citizenship Immigration Status 1-34 (see below)
					Hispanic Y/N (Optional)	1-6 (See below) (Optional)			
1.	(Self)	<input type="checkbox"/> YES <input type="checkbox"/> NO							
2.		<input type="checkbox"/> YES <input type="checkbox"/> NO							
3.		<input type="checkbox"/> YES <input type="checkbox"/> NO							
4.		<input type="checkbox"/> YES <input type="checkbox"/> NO							
5.		<input type="checkbox"/> YES <input type="checkbox"/> NO							
6.		<input type="checkbox"/> YES <input type="checkbox"/> NO							

**Race:** For each person applying for help, choose from the number(s) below that best describes their race and **write the number(s) above.**

1 - American Indian/Alaska 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 number(s) 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/Green Card holder)	3 - Asylee	4 - Refugee	5 - Cuban/Haitian entrant	6 - Paroled into the U.S. (for at least one year)
7 - Conditional entrant granted before 1980	8 - Battered spouse, child, or parent	9 - Victim of trafficking and his/her spouse, child, sibling, or parent	10 - Granted Withholding of Deportation or Withholding of Removal	11 - Member of a federally recognized Indian tribe or American Indian born in Canada	12 - Afghan or Iraqi Special Immigrant
13 - Qualified non-citizen	14 - Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)	15 - Paroled into the U.S. (for less than one year)	16 - Temporary Protected Status (TPS)	17 - Deferred Enforced Departure (DED)	18 - Deferred Action Status
19 - Lawful temporary resident (LTR)	20 - Granted an administrative stay or removal by DHS	21 - Granted Withholding of Removal under the Convention Against Torture (CAT)	22 - Resident of American Samoa	23 - Applicant for Special Immigrant Juvenile Status	24 - Applicant for Adjustment to LPR Status with an approved visa petition
25 - Applicant for Victim of trafficking visa	26 - Applicant for Asylum (with EAD or under age 14 with application pending for at least 180 days)	27 - Applicant Withholding of Deportation or Withholding of Removal (with EAD or under age 14 with application pending for at least 180 days)	28 - Registry applicant (with EAD)	29 - Order of supervision (with EAD)	30 - Applicant for Cancellation of Removal or Suspension of Deportation (with EAD)
31 - Applicant for Legalization under IRCA (with EAD)	32 - Applicant for Temporary Protected Status (TPS) (with EAD)	33 - Legalization under the LIFE Act (with EAD)	34 - Other/Unsure		

**4. Tax Filing Information (Fill out this section if you are applying for Medical Assistance)**

Please give the following information for every household member applying for medical assistance, even if the taxpayer 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?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of spouse or partner:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name(s) of dependents:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of the tax filer:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of spouse or partner:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name(s) of dependents:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of the tax filer:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of spouse or partner:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name(s) of dependents:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of the tax filer:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of spouse or partner:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name(s) of dependents:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of the tax filer:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of spouse or partner:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name(s) of dependents:	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of the tax filer:	

5. Please Answer the Following Questions About the People You Listed in Section 3 who are Seeking Benefits for Themselves.

**For household members seeking benefits who are not U.S. Citizens**, please give the information that appears on their immigration documents, if known. This will be used to see who can get benefits. If you need more space, please attach another piece of paper.

Name	Immigration Document Type (if known)	A-Number or I-94 Number (if known)	Card or Passport Number (if known)	SEVIS ID or Expiration Date (optional)	Other (Category Code or Country of Issuance, if known)	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?
						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**a. Is any applicant getting Medicaid, SNAP/Food, or Cash benefits in another state?**  Yes  No If, **YES**, Who? \_\_\_\_\_ Which Benefits? \_\_\_\_\_ Which State? \_\_\_\_\_

**b. Is any applicant pregnant?**  Yes  No If, **YES**, Who? \_\_\_\_\_ Due Date, (if known): \_\_\_\_\_  
Number of babies expected from this pregnancy (if known): \_\_\_\_\_

**c. Is any applicant imprisoned (detained or jailed)?**  Yes  No If, **YES**, Who? \_\_\_\_\_  
What facility? \_\_\_\_\_  
Date of imprisonment: \_\_\_\_\_ Date of release (if known): \_\_\_\_\_

**d. Is any applicant in the household receiving Supplemental Security Income (SSI)?**  Yes  No If, **YES**, Who? \_\_\_\_\_

**e. Does any applicant have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?**  Yes  No If, **YES**, Who? \_\_\_\_\_

**f. Does any child on this application have a parent who lives outside the home?**  Yes  No

Only complete questions g - k of this section if you are applying for Medical Assistance.

**g. Is any household member age 21 or younger and a full-time student?**  Yes  No If, **YES**, Who? \_\_\_\_\_

**h. Is there anyone in the household who is age 18 to 25 now, and who was in foster care and getting Medicaid before age 18?**  Yes  No If, **YES**, Who? \_\_\_\_\_ Which state? \_\_\_\_\_

**i. Is any applicant already in or going into a nursing home, hospital or treatment facility?**  Yes  No **If YES, who?** **What is the date of admission?** **Where was the applicant admitted from (e.g., home, hospital)?**

**j. If you said yes to question (h) above, what is the name and type of facility?**

Name of Nursing Home / Nursing Facility:	Name of Hospital:	Name of Intermediate Care Facility for the Intellectually Disabled (ICF/IID):	Enrolling with PACE? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Assisted Living Facility:
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**k. 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.**

**Have you or anyone living with you received earned income or expect to receive earned income this month?**  Yes  No **If yes, please complete the chart below.**

Please report your total income **before** taxes. If you are applying for medical assistance and you or another person in your household are offered health insurance from any employer, please fill out the Employer Coverage form attached to this application. If you do not qualify for Medicaid, the NM Health Insurance Exchange (NMHIX) may need to use information about any health coverage you might have through a job to figure out if you can get help paying for health insurance. Failure to complete this form will not delay your application for assistance

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 before taxes?	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 the Employer Coverage Form for Medicaid.
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Are any of the following taken from your earnings? (if applying for Medical Assistance)**

<input type="checkbox"/> <b>Student Loan Interest?</b> Who? _____ How Much \$ _____ How Often? _____	<input type="checkbox"/> <b>Other Type</b> Who? _____ How Much \$ _____ How Often? _____	<input type="checkbox"/> <b>Other Type</b> Who? _____ How Much \$ _____ How Often? _____
<input type="checkbox"/> <b>Other Type</b> Who? _____ How Much \$ _____ How Often? _____	<input type="checkbox"/> <b>Other Type</b> Who? _____ How Much \$ _____ How Often? _____	<input type="checkbox"/> <b>Other Type</b> Who? _____ How Much \$ _____ How Often? _____

**Tell Us About Your Other Income. Have you or anyone living with you received any income or expect to receive any income this month?**  Yes  No

**If yes, please complete the chart below.**  
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. Report child support or spousal support if you are applying for SNAP or Cash. If you are only applying for Medical Assistance, you do not need to report child support income.

Person with income	Unearned Income from?	How Often Received? (Yearly, Monthly, Biweekly, Weekly, etc.)	How much does this person 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 of the year? **If yes, fill out the chart 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 applying for Medical Assistance)**

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.

Person with Unpaid Medical Bills	Bill Months

**Please list all public and private health insurance, including Medicare information, for you and all people living with you who are applying for Medical Assistance.**

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 three managed care organizations (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 switch to a different MCO within 3 months of enrollment.

**Special Information for Native Americans**

**Are you Native American? If so, you do not have to choose an MCO. If you do not choose an MCO, you will be in fee-for-service (FFS) Medicaid. This is automatic. If you need long-term care services, you will have to choose an MCO. (These services include Institutional Care and Home and Community-Based Services Waivers.) Also, if you have Medicare, you will have 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](http://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:

**Presbyterian Health Plan**  
(888) 977-2333 [www.phs.org](http://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:

**Western Sky Community Care**  
(844) 543-8996 [www.westernskycommunitycare.com](http://www.westernskycommunitycare.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 (NMHIX) can also get services from the Indian Health Service, tribal health programs, or urban Indian health programs. If you or your family members are Native American or Alaska Natives, you may not have to pay cost-sharing and may get special monthly enrollment periods for insurance through the NMHIX. 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 not 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
<ul style="list-style-type: none"> <li>• Nursing Home</li> <li>• Medicare Savings Program (13 &amp; 16 only)</li> <li>• Waiver Services</li> <li>• Working Disabled Individual</li> </ul>	<ul style="list-style-type: none"> <li>• SNAP</li> <li>• Cash Assistance</li> <li>• LIHEAP</li> </ul>

**10. Parents Not Living with their Children (if applying for Cash Assistance only)**

Do you take cash aid and medical aid for your kids? If so, you grant HSD rights to collect child support, and spousal support, and medical support from an absent parent. You grant them rights to collect spousal and medical support too. Please list all the information for your children's parent(s) who are not living with you. If you think working with the Child Support Enforcement Division (CSED) to collect support will harm you or your children, you may have good cause to not cooperate.

Is any applicant a victim of Family or Domestic 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			
			<input type="checkbox"/> K-12	<input type="checkbox"/> GED	<input type="checkbox"/> Certificate	<input type="checkbox"/> College
			<input type="checkbox"/> K-12	<input type="checkbox"/> GED	<input type="checkbox"/> Certificate	<input type="checkbox"/> College
			<input type="checkbox"/> K-12	<input type="checkbox"/> GED	<input type="checkbox"/> Certificate	<input type="checkbox"/> College

**12. Things you Own (Resources/Assets)**

Do you or anyone living with you have resources this month?  Yes  No

If yes, please complete the chart below.

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 there is one.
		\$	
		\$	
		\$	
		\$	

**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 ▶	\$ _____
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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? ▶	\$ _____
---	--------------------------------	----------

Full Time or Temporary Shelter Costs: Please put all out of pocket money you spend on shelter. If you are buying or renting a home, please list property tax and any insurance you pay. If you are homeless, please list any money you spend on things such as laundry, temporary shelter or other things you pay for that provide you shelter during the month.

Check any of the boxes below that best describes your **Living Arrangement** and list the amount you pay out of pocket.

<input type="checkbox"/> Mortgage \$ _____	<input type="checkbox"/> Rent Does Not Include Utilities \$ _____	<input type="checkbox"/> Rent Includes Utilities \$ _____	<input type="checkbox"/> Homeless \$ _____
--	---	---	--

<input type="checkbox"/> Public Housing \$ _____	<input type="checkbox"/> Other _____ \$ _____
--	---

Heating and Cooling ▶	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Lifeline/Link-Up:</b> 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 ▶	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Telephone ▶	<input type="checkbox"/> Yes <input type="checkbox"/> 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

<p>Do you have an energy emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If Yes, check any of the items listed below that apply to you today.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Non-working furnace/boiler/heat system</li> <li><input type="checkbox"/> Out of fuel (propane, wood, pellets, coal, oil)</li> <li><input type="checkbox"/> Less than 10% fuel remaining (propane, wood, pellets, coal, oil)</li> <li><input type="checkbox"/> Need utility/fuel deposit</li> <li><input type="checkbox"/> Disconnected- your fuel supplier has ALREADY turned off your service</li> <li><input type="checkbox"/> Disconnection Notice- your fuel supplier has NOT turned off your services but is warning you they will if not acted upon.</li> </ul>	<p>Is the energy emergency life threatening? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	---

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you receive subsidized assistance for this energy bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a shared meter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this used for a business? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Utility Company Name: _____	Account Number: _____	Name on the Account: _____
<b>Do you have any other energy usage than what you are requesting LIHEAP assistance with?</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No, If No, please tell us why: <input type="checkbox"/> You are Homeless <input type="checkbox"/> You live in a rural area <input type="checkbox"/> No Utilities available <input type="checkbox"/> Other _____		
<b>B. ▼ Please provide your energy usage information for your home ▼</b>		
<b>What is your primary heating source?</b>		
<b>Choose one:</b> <input type="checkbox"/> Same as above in Section 14A (Skip to Section 14C) <input type="checkbox"/> Electric <input type="checkbox"/> Propane <input type="checkbox"/> Wood <input type="checkbox"/> Natural Gas <input type="checkbox"/> Pellets <input type="checkbox"/> Coal <input type="checkbox"/> Kerosene		
Is this a shared meter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this used for a business? <input type="checkbox"/> Yes <input type="checkbox"/> No	Utility Company Name: _____ Account Number: _____ Name on the Account: _____
<b>C.</b>		
<b>Do you have an account for electricity service?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes, please complete the section below. If your heating source in <b>Section B</b> is electric or you selected No above, <b>DO NOT</b> complete the section below		
Is this a shared meter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this used for a business? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Utility Company Name: _____	Account Number: _____	Name on the Account: _____

<b>15. Please Answer the Following Questions About the People Listed in Section 3 that are asking for benefits.</b>					
Buy and prepare meals together? If no, who is separate? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reduced work hours to less than 30 hours per week in the last 30 days? If yes, Who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Worker(s) on strike or lockout?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is anyone a Fleeing Felon(s)? If yes, Who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Voluntarily quit job(s) in the last 30 days? If yes, Who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	In violation of probation or parole? If yes, Who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone been convicted of any in section 18 below?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Living on a Native American Reservation? Name of Reservation? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is anyone a veteran? If yes, Who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Is this person in compliance with terms of their sentence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting help from the Food Distribution Program on Indian Reservation (FDPIR)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting Tribal TANF or General Assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or any member of your household been convicted of receiving duplicate SNAP benefits in any State after September 22, 1996?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or any member of your household been convicted of buying or selling SNAP benefits over \$500 after September 22, 1996?"	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disqualified from an assistance program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paying room and board? If yes, Who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> <input type="checkbox"/>

**16. Please Sign This Application (Your authorized representative may also sign here)**

**Your signature makes this application valid. This application cannot be processed unless signed. Your signature also is an indication of the following:**

- **What I have said and written to HSD is true and complete. If I give incorrect facts, I can be charged with a crime. If I hide or leave out facts, I can be charged with a crime. If HSD learns that I have given untrue or incomplete factual information, my SNAP may be denied or reduced.**
- **Privacy Act statement:** The collection of the application information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Food Stamp Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of food stamp benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.
- 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.
- If asked, 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 that offer related assistance for which I may be eligible.
- I understand that if I get SNAP, Cash, or LIHEAP benefits for which I am not eligible, then I may have to pay HSD back.
- I know that HSD will check the information that I give. HSD may use computers or other ways 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 where Medicaid recipients are 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 exclusions may apply.
- A person who is applying for or receiving Medicaid or Cash Assistance shall assign to HSD all rights against any and all individuals for medical support or payments for medical expenses paid on the applicant's or recipient's behalf and the behalf of any other person for whom application is made or assistance is received.
- For parents who qualify for Medicaid: I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the Child Support Enforcement Division (CSED) and I may not have to cooperate. Non-cooperation with CSED may result in termination of my Medicaid eligibility.
- 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 (if applicable)	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)  
IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.  YES  NO

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
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**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, 325 Don Gaspar, Suite 300, Santa Fe, NM 87503, (phone: 1-800-477-3632).**

18. Convicted Felons

Indicate in section 15 on page 13 if you have been convicted of any of the following:

- (1) Aggravated sexual abuse under section 2241 of title 18, United States Code;
- (2) Murder under section 1111 of title 18, United States Code;
- (3) An offense under chapter 110 of title 18, United States Code;
- (4) A Federal or State offense involving sexual assault, as defined in section 4002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or
- (5) An offense under State law determined by the Attorney General to be substantially similar to an offense described in clause (1), (2), or (3); and
- (6) The individual is fleeing to avoid prosecution, or custody or confinement after conviction, under the law of the place from which the individual is fleeing, for a crime or attempt to commit a crime, that is a felony, or in New Jersey a high misdemeanor, under the law of the place from which the individual is fleeing; or violating a condition of probation or parole imposed under a federal or state law. not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

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# Program Application Information Pages

You may keep this information for your records

## 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 1-800-659-1779 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](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 Agriculture Office 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](mailto: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](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. 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 household's 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 you fail or refuse to work with the Child Support Enforcement Division (CSED) office, your cash benefits will decrease and eventually the case will close, and adults in the household may lose their medical assistance.

## 5. Interview

Most medical assistance programs that you can apply for with this application do **not** require an interview.

### (a) For SNAP/Cash 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 your application is received by the office. Applications received after business hours will be considered received as of the next business day.
- Most Medical assistance programs do not require an interview.

### (b) May I have a telephone interview?

If your category of medical assistance requires an interview, we will do the interview by telephone unless you want us to do it in-person.

For SNAP/Cash, you may have a telephone interview for any of these reasons:

- Disability
- Age 60+
- Live too Far from Office
- Illness
- Working 20 or more hours/week
- Transportation
- Caring for a Child Under Age 6
- Bad Weather
- Caring for Others
- Other Hardships, please talk to ISD

## 6. Proof Information

HSD will check electronic data sources to see if it can verify your income and other information you provided on this application without requiring paper documentation. If HSD cannot verify your income and other information through electronic data sources, then HSD will ask you to provide proof of the information you provided on your application. You will receive a letter in the mail asking you for this information. If you need more time to provide proof to HSD, you may ask for more time by contacting ISD.

### What proof should I bring to the interview for SNAP or Cash?

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 You May be Asked to Give HSD
		Family or Adult	Child Only	Elderly/Disabled			
▪ Where you Live	✓	✓	✓	✓	✓	✓	Utility bill, 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. <b>Note:</b> The Medicaid program will require specific identification proof.
▪ Relationship					✓		
▪ Age							

<ul style="list-style-type: none"> <li>▪ <b>U.S. Citizenship</b></li> </ul>		✓	✓	✓			<p>Most programs do not require proof of U.S. Citizenship. For medical assistance, the federal government requires that all individuals give certain ORIGINAL documents (not copies) that verify Citizenship, Identity or proof of Legal Permanent Status. Original documents will be copied and returned.</p>
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							<b>Proof of Citizenship and ID together</b> <ul style="list-style-type: none"> <li>▪ A Passport</li> <li>▪ A certificate of naturalization (Form 550 or N-570)</li> <li>▪ A certificate of U.S. Citizenship (N-560 or N-561)</li> <li>▪ A certificate of Indian Blood (CIB)</li> </ul>	<b>Proof of Citizenship Alone</b> <ul style="list-style-type: none"> <li>▪ U.S. birth certificate</li> </ul> <p>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.</p>
▪ <b>Immigrant Status</b>	✓	✓	✓	✓	✓	✓	If you are an immigrant applying for assistance, you may have to provide original USCIS (formerly the INS) records.	
▪ <b>Disability</b>				✓	✓	✓	Medical records that say how long you will be disabled, whether or not you can work, and if constant help/care is needed.	
▪ <b>Pregnancy</b>						✓	Medical records that say when your baby is due	
▪ <b>School Attendance</b>							Current report card or letter from the school saying whether your child is attending school	
▪ <b>College Student</b>	✓					✓	Letter from the college saying that you are either a part-time or full-time student	
▪ <b>Student Financial Aid</b>	✓					✓	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	
▪ <b>Income</b> the most recent 30-day period or all from last month	✓	✓	✓	✓	✓	✓	<b>Earned Income:</b> Check stubs, a letter from the employer with the hours you will work and the pay you will get. If you are <b>self-employed</b> , you may give your caseworker a copy of your income tax forms, business records or personal wage records. <b>Unearned Income:</b> 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.	
▪ <b>Loss of a Job (60 days)</b>	✓	✓	✓	✓	✓	✓	Letter from the employer	
▪ <b>Value of Things You Own</b>				✓			Resources/Assets: Recent bank statement or letter of value	
▪ <b>Things You Transferred</b>	✓			✓	✓		Recent statement or letter of value	
▪ <b>Medicare Part A</b>				✓			ID card or letter from Social Security Administration	
▪ <b>Child Support Paid</b>	✓						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.	
<b>Optional Proof</b> —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.								
▪ <b>Child/Adult Care Costs</b>							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.	
▪ <b>Medical Costs</b> Elderly or Disabled only	✓			✓				
▪ <b>Home Rent/Owner Costs</b>								
▪ <b>Heating/Cooling Costs</b>						✓		

## 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 meets all other eligibility requirements can get Medicaid right away. 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/Green Card holder)	3 – Asylee	4 – Refugee	5 – Cuban/Haitian entrant; Iraqi or Afghan with special immigration status	6 – Paroled into the U.S. (for at least one year)
7 – Conditional entrant granted before 1980	8 – Battered spouse, child, or parent	9 – Victim of trafficking and his/her spouse, child, sibling, or parent	10 – Granted Withholding of Deportation or Withholding of Removal	11 – Member of a federally recognized Indian tribe or American Indian born in Canada	12 – Afghan or Iraqi Special Immigrant
13 – Qualified non-citizen	14 – Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)	15 – Paroled into the U.S. (for less than one year)	16 – Temporary Protected Status (TPS)	17 – Deferred Enforced Departure (DED)	18 – Deferred Action Status
19 – Lawful temporary resident (LTR)	20 – Granted an administrative stay or removal by DHS	21 – Granted Withholding of Removal under the Convention Against Torture (CAT)	22 – Resident of American Samoa	23 – Applicant for Special Immigrant Juvenile Status	24 – Applicant for Adjustment to LPR Status with an approved visa petition
25 – Applicant for Victim of trafficking visa	26 – Applicant for Asylum (with EAD or under age 14 with application pending for at least 180 days)	27 – Applicant Withholding of Deportation or Withholding of Removal (with EAD or under age 14 with application pending for at least 180 days)	28 – Registry applicant (with EAD)	29 – Order of supervision (with EAD)	30 – Applicant for Cancellation of Removal or Suspension of Deportation (with EAD)
31 – Applicant for Legalization under IRCA (with EAD)	32 – Applicant for Temporary Protected Status (TPS) (with EAD)	33 – Legalization under the LIFE Act (with EAD)	34 – Other/Unsure		

## 8. Social Security Number (SSN) Requirements

### Why do I need to provide a Social Security Number (SSN)?

To get SNAP or Medicaid benefits you must have a Social Security number (SSN), or have applied for one, or have good cause for not applying for one [7 C.F.R. § 273.6 and 42 C.F.R. § 435.910]. All people in a household applying for SNAP benefits must give the ISD office their SSNs [7 C.F.R. § 273.6]. ISD must check the SSNs of everyone in the household with the Social Security Administration (SSA). ISD cannot delay or deny SNAP benefits while waiting to check a SSN [7 C.F.R. § 273.2]. If the applicant cannot remember their SSN or is unsure if they have one, they can contact SSA.

### How will the Department use my SSN?

Prevent duplicate participation; to facilitate mass changes in benefits; to determine the accuracy of the information given by the household member; and the SSN(s) will be computer cross-checked with SSNs appearing in other personal data files what those files are, whether within the Department, in other governmental agencies. The Department will regularly use the SSN to obtain and use wage and benefit information from other sources for purposes of verifying eligibility for SNAP and the amount of SNAP benefits. These sources include, but are not limited to: any federal or state agency, providers under contract with the Department, welfare departments in other states; and banks and other financial institutions

### What happens if I do not provide or do not have an SSN?

The household member who fails to provide or apply for SSN number without good cause will be disqualified and not receive benefits. [7 C.F.R. § 273.6] This disqualification applies only to that individual household member and not to the entire household. [Id.] The disqualified individual's income and resources can affect the entire household's benefit amount and eligibility. If the disqualified individual household member provides their SSN to ISD they may become eligible for benefits. If the disqualified individual household member provides proof of an SSN application, or good cause for why an SSN application was not completed, they may become eligible for benefits. [7 C.F.R. § 273.6]

### When I would have good cause for not applying for an SSN?

Applicants without SSNs must apply for one before receiving benefits unless there is "good cause." [7 C.F.R. § 273.6] "Good cause" means that the person tried to apply for a SSN but cannot, yet. [7 C.F.R. § 273.6] For example, someone may have "good cause" if their Social Security office will not take his SSN application because he does not have proof of his age, and Social Security and must send away for his birth certificate. If the ISD office finds good cause for not trying to get a Social Security number, an applicant can get SNAP benefits for one month in addition to the month of application [7 C.F.R. § 273.6]. The ISD office will then decide if there is good cause for not applying for a SSN at the end of each month [7 C.F.R. § 273.6]. Eventually, either the applicant will get an SSN, or lack good cause for not applying for one.

## 9. After You Submit Your Application

### (a) How soon will my application be approved or denied?



96	86	97	87	98	88	99	89	90	80
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SNAP/Food Assistance Staggered Issuance Schedule															
Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN
	11		01		12		02		13		03		14		04
	31		21		32		22		33		23		34		24
<b>1</b>	51	<b>2</b>	41	<b>3</b>	52	<b>4</b>	42	<b>5</b>	53	<b>6</b>	43	<b>7</b>	54	<b>8</b>	44
	71		61		72		62		73		63		74		64
	91		81		92		82		93		83		94		84
	15		05		16		06		17		07		18		08
	35		25		36		26		37		27		38		28
<b>11</b>	56	<b>12</b>	46	<b>13</b>	57	<b>14</b>	47	<b>15</b>	58	<b>16</b>	48	<b>17</b>	59	<b>18</b>	49
	76		66		77		67		78		68		79		69
	96		86		97		87		98		88		99		89
	105		05		11		01		12		02		13		03
	25		15		26		16		27		17		28		18
	45		35		46		36		47		37		48		38
	65		55		75		65		85		75		95		85
	80		70		90		80		00		90		10		00
	20		10		30		20		40		30		50		40
	60		50		70		60		80		70		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
- **Medicaid** – Your Medicaid will be approved for 12 months. You should report any changes that could affect your eligibility within 10 days; see below.
- **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.
- **Medicaid** – Medicaid recipients are required to report certain changes that might affect their eligibility to ISD within 10 days from the date the change happened. Changes you should report include the following:
  1. Living arrangements or change of address: Report any change in where an eligible recipient lives or gets mail.

2. **Household size:** Report any change in the household size, including the death of an individual who is included in the household and/or any pregnancies of household members.
3. **Enumeration:** Report any new social security number of individuals receiving Medicaid benefits in the household, including any newborn receiving Medicaid.
4. **Income:** Report any increase or decrease in the amount of income. For some categories of Medicaid, such as children and pregnant women, changes in income do not affect eligibility until the renewal date.
5. **Resources:** Reporting changes in what you own (such as property or money in the bank) is only required for Institutional Care, Waiver, Working Disabled Individuals, and Supplemental Security Income (SSI) Extension Medicaid.

**(g) Will I have to participate in the New Mexico Works Program?**

- **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: **1<sup>st</sup> Sanction – 25% cash reduction; 2<sup>nd</sup> – 50% cash reduction; and the 3<sup>rd</sup> – 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 an 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

**(h) What other help is available?**

- By accessing the link below, you will find resource listings available throughout New Mexico. You will find the resource listings by county.  
[http://www.hsd.state.nm.us/LookingForAssistance/Field\\_Offices\\_1.aspx](http://www.hsd.state.nm.us/LookingForAssistance/Field_Offices_1.aspx)

## 10. 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) 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.

## 11. 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 SNAP/food assistance 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 buying or selling SNAP/food assistance of \$500 or more after September 22, 1996 shall be permanently ineligible to participate in the Program. (Any violation).**

**Anyone convicted for trading SNAP/food assistance for firearms, ammunition, or explosives will be permanently ineligible to participate in the Program (Any violation).**

## 12. 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. Anytime 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 a decision by the New Mexico Health Insurance Exchange (NMHIX), you may appeal the action by contacting the NMHIX at 1-800-31802596 and inform the NMHIX that you believe their action should be reconsidered. You may authorize someone else to represent you in the appeals process.
- After you ask for a fair hearing, HSD or the NMHIX will send you a letter telling you the date, time and place where your hearing will be held. HSD hearings are usually at the HSD office. The hearing will be conducted by a hearing officer from the HSD Fair Hearings Bureau or the NMHIX. Prior to the hearing, you or your representative can look at your case record and any proof that will be used to decide your case. You will tell why you believe the HSD or NMHIX decision to be wrong. You may bring witnesses and present proof. You may question the county office or the NMHIX about the action taken and the proof presented. You may represent yourself or you may be represented by a friend, household member or an attorney. For information on where you can get free legal help, call 1-833-LGL-HELP (1-833-545-4357).
- After the hearing, the hearing officer will make a report. The HSD Division Director or the NMHIX Director will decide whether the action was right or wrong. After your case has been decided, you will be sent a letter telling you about the decision and why the decision was made. (Revised 8/30/17)

# Employer Coverage Form

You don't need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

**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 (NMHIX) 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. The NMHIX will 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.

Employee Name (First, Middle, Last)	Employee 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).

List the names of anyone else who is eligible for coverage from this job:

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 \_\_\_\_\_

What change, if any, will the employer make for the new plan year?

- No change.
- Employer won't offer health coverage.
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard.

Date of change, if applicable: \_\_\_\_\_

**THIS PAGE IS LEFT INTENTIONALLY BLANK**

PERSONAL INFORMATION					This information <u>not</u> to be copied.	
1	NAME: Last	First	Middle Name or Initial	Gender	Birth Date	Social Security Number
PHYSICAL STREET ADDRESS WHERE YOU LIVE NOW						
2	Street Address		Apartment, Unit, or Lot #	City	Zip	
ADDRESS WHERE YOU GET YOUR MAIL (If different from above)						
3	Mailing Address		City	Zip		
4	If you are changing your name on this application, under what full name were you previously registered? Last, First, Middle				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. <input type="checkbox"/>	7	DAYTIME TELEPHONE NUMBER (optional)	
				May the County Clerk make this telephone number public for election purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO		POLL WORKER
						Would you like to serve as an election day precinct worker? <input type="checkbox"/> 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		ATTESTATION OF QUALIFICATION	
If you checked "NO" to any of the questions above, do not complete this form.				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.		
If you have been convicted of a felony and are currently on parole or supervised probation do not complete this form.				SIGN YOUR FULL NAME OR MARK ON THE LINE BELOW:		
				_____		
TODAY'S DATE						
Month / Day / Year						
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 PCT. MUN. PRC DIST. REP DIST. SEN. DIST. SCHOOL C.C.

Date / County Clerk / Filing Clerk

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 public 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.**