Information Sheet for Application for Assistance

Health Care Authority

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.nm.gov
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

Or complete an application 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 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

Or call 1-833-862-3935
TTY: 711

Assistance Programs

Medical Assistance

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:

Complete Sections 1-9 & 16

- Newborns
- Children through age 18
- Parent(s)/Caretaker(s)
- Pregnant women
- Low-income adults
- Emergency Medical Services for Non-Citizens (EMSNC)

Complete Sections 1-9, 12-13 & 16

- Aged, blind and disabled individuals
- Working Disabled Individuals
- Institutional Care
  - Nursing Facility
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
  - Program for All-inclusive Care for the Elderly (PACE)
- Home and Community Based Services Waivers:
  - Community Benefit (CB) Waiver
  - Developmental Disabilities Waiver (DDW)
  - Medically Fragile Waiver (MFW)
  - Mi Via Waiver (MVW)

NM 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. 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.

Medicare Savings Program

Medicaid benefit that provides help with paying for your Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) premiums and Medicare deductibles.

Complete Sections 1-9, 12-13 & 16

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) helps low-income households purchase food to maintain health and productivity. SNAP benefits are easy to use at grocery stores and also support adults in securing employment and increasing their earnings, helping to promote long-term financial stability.

Complete Sections 1-3, 5 -7, 11 - 13, 15 & 16 so ISD can determine benefits faster.

Cash Assistance

Temporary Assistance for Needy Families (TANF) provides cash assistance to families who qualify.

OR

General assistance can provide cash assistance for dependent needy children and disabled adults who are not eligible for assistance under a federally matched cash assistance program, such as New Mexico Works (NMW) or the Federal program of Supplemental Security Income (SSI).

Complete Sections 1-3, 5 -7, 10-13, 15 & 16

Low Income Home Energy Assistance Program (LIHEAP)

The Low-Income Home Energy Assistance Program (LIHEAP) assists eligible Low Income Families and Individuals with their heating and cooling costs.

Complete Sections 1-3, 5 -7, 14 & 16

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
Email 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?	Do you intend to remain in New Mexico?	Are you homeless?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Do you want to get your information sent to your email? If YES, please fill out your most current e-mail address above. ☐ YES ☐ NO

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

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

Sign Here 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 give 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 ensure 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.
This information will be used to determine an exception from the ABAWD Work Requirements.

Name (First and Last)	Relationship	Applying for assistance?	Sex M/F	Date of Birth	Ethnicity Hispanic Y/N (Optional)	Race 1-6 (See below) (Optional)	*Tribal Affiliation (Optional)	Social Security Number (SSN) – **required if you have one** (optional for non-applicants)	Citizenship Immigration Status 1-38 (see below)
1.	(SELF)	☐YES ☐NO							
2.		☐YES ☐NO							
3.		☐YES ☐NO							
4.		☐YES ☐NO							
5.		☐YES ☐NO							
6.		☐YES ☐NO							
7.		☐YES ☐NO							
8.		☐YES ☐NO							
9.		☐YES ☐NO							
10.		☐YES ☐NO							

1. What is your preferred written language?	
2. What is your preferred spoken language?	
3. Do all the adults in your household speak the same language as you?	☐ YES ☐ NO
4. Are any adults living with you fluent in English?	☐ YES ☐ 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 – US Citizen	2 – Lawful Permanent Resident (LPR/Green Card Holder)	3 – Asylee	4 – Refugee	5 – Cuban/Haitian Entrant	6 – Paroled into the US (for at least one year)
7 – Conditional entrant granted before 1980	8 - Battered spouse, child, or parent or un-remarried surviving spouse	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 – Individual with non-immigrant status	14 – Paroled into the US (for less than one year)	15 – Temporary Protected Status (TPS)	16 – Deferred Enforced Departure (DED)	17 – Deferred Action Status	18 – Lawful temporary resident (LTR)
19 – Granted an administrative stay or removal by DHS	20 – Granted Withholding of Removal under the Convention Against Torture (CAT)	21 – Resident of American Samoa	22 – Applicant for Special Immigrant Juvenile Status	23 – Applicant for Adjustment to LPR Status with an approved visa petition	24 – Applicant for Victim of trafficking visa
25 – Applicant for Asylum (with EAD or under age 14 with application pending for at least 180 days)	26 – Applicant Withholding of Deportation or Withholding of Removal (with EAD or under age 14 with application pending for at least 180 days)	27 – Registry applicant (with EAD)	28 – Order of supervision (with EAD)	29 – Applicant for Cancellation of Removal or Suspension of Deportation (with EAD)	30 – Applicant for Legalization under IRCA (with EAD)

31 – Applicant for Temporary Protected Status (TPS)	32 – Legalization under the LIFE Act (with EAD)	33 – Amerasian	34 – Hmong/Laotian
35 – COFA citizens of the Federated States of Micronesia, Marshall Islands, and Palau who lawfully reside in the U.S. under Section 141 of the Compacts of Free Association with the United States and their governments.	36 – Lawfully Present but not listed	37 – Other	38 – 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 Federal income tax return next year?**	**C** **Will this person file jointly with a spouse/partner?**	**D** **Does this person have any tax dependents?**	**E** **Is this person claimed as a tax dependent on someone else's tax return?**	**F** **How is this person related to the tax filer?**
	☐ YES ☐ NO	☐ YES ☐ NO If **yes**, name of spouse or partner:	☐ YES ☐ NO If **yes**, name(s) of dependents:	☐ YES ☐ NO If **yes**, name of tax filer:	
	☐ YES ☐ NO	☐ YES ☐ NO If **yes**, name of spouse or partner:	☐ YES ☐ NO If **yes**, name(s) of dependents:	☐ YES ☐ NO If **yes**, name of tax filer:	
	☐ YES ☐ NO	☐ YES ☐ NO If **yes**, name of spouse or partner:	☐ YES ☐ NO If **yes**, name(s) of dependents:	☐ YES ☐ NO If **yes**, name of tax filer:	
	☐ YES ☐ NO	☐ YES ☐ NO If **yes**, name of spouse or partner:	☐ YES ☐ NO If **yes**, name(s) of dependents:	☐ YES ☐ NO If **yes**, name of tax filer:	
	☐ YES ☐ NO	☐ YES ☐ NO If **yes**, name of spouse or partner:	☐ YES ☐ NO If **yes**, name(s) of dependents:	☐ YES ☐ NO If **yes**, name of 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 US Military?
						☐ YES ☐ NO	☐ YES ☐ NO
						☐ YES ☐ NO	☐ YES ☐ NO
						☐ YES ☐ NO	☐ YES ☐ NO
						☐ YES ☐ NO	☐ YES ☐ 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?	
		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	If **YES**, who?	

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 anyone applying who is age 18 to 25 who was in foster care and getting Medicaid when they turned 18?	☐ YES ☐ NO	If **YES**, who?	Which state?
i. Is any applicant already in or going into a nursing home, hospital or treatment facility?	If **YES**, who?	What is the date of admission?	
		Where was the applicant admitted from?	

Section 5 continued on next page

Section 5 continued

j. If you said yes to question (i) 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 in PACE? ☐ YES ☐ NO	Name of Assisted Living Facility:

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. You are not required to complete the Employer Coverage Form for Medicaid.

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 attached to this application.
				$	☐ YES ☐ NO
				$	☐ YES ☐ NO
				$	☐ YES ☐ NO

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

☐ **Student Loan Interest?** Who? _____ How Much $ _____ How Often? _____	☐ **Health Insurance?** Who? _____ How Much $ _____ How Often? _____	☐ **Health Savings/Flexible Spending Account?** Who? _____ How Much $ _____ How Often? _____
☐ **Other Type** Who? _____ How Much $ _____ How Often? _____	☐ **Other Type** Who? _____ How Much $ _____ How Often? _____	☐ **Other Type** Who? _____ How Much $ _____ How Often? _____

Tell Us About Your Other Income. 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 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 Health Care Authority. 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 and Blue Shield of New Mexico**

(**866) 689-1523**
www.bcbsnm.com/medicaid
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 Turquoise Care**

(888) 977-2333
www.phs.org/health-plans/turquoise-care-medicaid
By checking this box, I wish to enroll all Medicaid recipients in my household with this MCO.

OR

Only the Medicaid recipients from this household that are listed here should be enrolled with this MCO:

☐ **Molina Healthcare of New Mexico**

(844) 862-4543
www.welcometomolina.com/nm
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:

☐ **UnitedHealthcare Community Plan of New Mexico**

(877) 236-0826
myuhc.com/communityplan/new-mexico/plans
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
• Nursing Home • Medicare Savings Program (13 & 16 only) • Waiver Services • Working Disabled Individual	• SNAP • Cash Assistance • LIHEAP

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 HCA 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 Services Division (CSSD) 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 Student	Graduation Date	Grade			
			☐ K - 12	☐ GED	☐ Certificate	☐ College
			☐ K - 12	☐ GED	☐ Certificate	☐ College
			☐ K - 12	☐ GED	☐ Certificate	☐ College
			☐ K - 12	☐ GED	☐ Certificate	☐ 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 on next page ~~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).

Section 12 continued on next page

Section 12 continued

Examples of things you own include, but are not limited to: Cash on hand, checking account(s), savings account(s), trust(s), CD – Certificate(s) of Deposit, royalties, life or burial insurance, stocks or bonds, retirement account, livestock, house/land that you do not live on, or recreational 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 your MONTHLY out-of-pocket expenses.
Do not include any 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 listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.**

Childcare or Adult Dependent Care ► $		Mileage Round Trip for Dependent Care:	$
Who/What agency is getting paid the Child Care expenses?			
Medical Expenses for applicants who are Elderly/Disabled, Including Medicare premiums:	$	Court Ordered Child Support/Frequency:	$ /

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 with shelter during the month.

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

☐ Mortgage $	☐ Rent Does Not Include Utilities $	☐ Rent Includes Utilities $	☐ Homeless $
☐ Public Housing $		☐ Other $	

Heating and Cooling ►	☐ YES	☐ NO	**Lifeline/Link-Up:** You may be eligible for telephone discounts on monthly service and initial telephone installation or activation fees. Contact your telephone provider for more information.
Water, Sewer and Trash ►	☐ YES	☐ NO	
Telephone ►	☐ YES	☐ NO	Telephone Company Name:

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

A. ▼ LIHEAP Information ▼

Do you need LIHEAP for: ☐ Heating ☐ Cooling	**Do you have an energy emergency?** ☐ YES ☐ NO
If **Yes**, check any of the items listed below that apply to you today. ☐ Non-working furnace/boiler/heat system ☐ Out of fuel (propane, wood, pellets, coal, oil) ☐ Less than 10% fuel remaining (propane, wood, pellets, coal, oil) ☐ Need utility/fuel deposit ☐ Disconnected - your fuel supplier has ALREADY turned off your service ☐ Disconnection Notice - your fuel supplier has NOT turned off your services but is warning you they will if not acted upon.	**Is the energy emergency life threatening?** ☐ YES ☐ NO

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

Is this energy bill included in your rent? ☐ YES ☐ NO	Do you receive subsidized assistance for this energy bill? ☐ YES ☐ NO
Is this a shared meter? ☐ YES ☐ NO	Is this used for a business? ☐ YES ☐ NO

Utility Company Name:	Account Number:	Name on Account:

Do you have any other energy usage than what you are requesting LIHEAP assistance with? ☐ YES ☐ NO

If **no**, please tell us why: ☐ You are Homeless ☐ You live in a rural area ☐ No Utilities available ☐ Other:

B. ▼ Please provide your energy usage information for your home. ▼

What is your primary heating source?

Choose one: ☐ Same as above in Section 14A (Skip to Section 14C) ☐ Electric ☐ Propane ☐ Wood ☐ Natural Gas ☐ Pellets ☐ Coal ☐ Kerosene

Is this a shared meter? ☐ YES ☐ NO	Is this used for a business? ☐ YES ☐ NO

Utility Company Name:	Account Number:	Name on Account:

C. ▼ Electric Service Account Information ▼

Do you have an account for electricity service? ☐ YES ☐ NO – If yes, please complete the section below.

If your heating source in **Section B** is electric or you selected **No** above, **DO NOT** complete the section below

Is this a shared meter? ☐ YES ☐ NO	Is this used for a business? ☐ YES ☐ NO

Utility Company Name:	Account Number:	Name on Account:

D. Weatherization Assistance: If you have qualified for LIHEAP, you may also qualify for the NM Energy$mart Weatherization Program. If you are interested in applying for the Weatherization Program, please call the NM Mortgage Finance Authority at 1-800-444-6880 for details.

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

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

A. 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 HCA 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 HCA 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 HCA. If I cannot get proof, I know that I can ask HCA to help me and I will let HCA contact other people, and companies to get proof.
- I will let HCA 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 HCA back.
- I know that HCA will check the information that I give. HCA may use computers or other ways to check the information on this form.
- I know that HCA 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 HCA. 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 HCA for the purposes of eligibility and determination of this and future applications, benefit determination, and program evaluation and analysis.
- 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 HCA. HCA 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 HCA 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 HCA a copy of the trust document, including all attachments and related information. HCA 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, HCA 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 HCA 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 HCA 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 Services Division (CSSD) and I may not have to cooperate. Non-cooperation with CSSD 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).

Applicant’s Signature:	Name of Witness (Witnessed only if applicant signs by mark or thumbprint)	Date
Authorized Representative Signature:	Signature of Witness (Witnessed only if applicant signs by mark or thumbprint)	Date

B. Application Withdrawal

To withdraw your application for any program, initial the box of the program ▶

SNAP	Medicaid	Cash	LIHEAP

17. Register to Vote

If YOU are NOT registered to vote where you live now, <u>Would you like to register to vote here today?</u> (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 opportunity to register to vote at this location. If you would like help 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 in private.

IMPORTANT: Applying to register or declining to register to vote WILL NOT AFFECT the amount of assistance that you will be provided by this agency.

Signature	Date

CONFIDENTIALITY: Whether you decide to register to vote or not, your decision will remain confidential. **IF YOU BELIEVE THAT SOMEONE HAS INTERFERED with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register, or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:**
The Office of the Secretary of State, 325 Don Gaspar, Suite 300, Santa Fe, NM 87503, phone 1-800-477-3632

18. Convicted Felons

Indicate in Section 15 on page 15 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 40002(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 Health Care Authority, American Disabilities Act (ADA) coordinator at 1-505-709-5788 or by dialing 711. HCA requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (Revised 04/22/24)

2. Your Civil Rights/Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. Mail: Food and Nutrition Service, USDA 1320 Braddock Place, Room 334, Alexandria, VA 22314
2. Fax: (833) 256-1665 or (202) 690-7442
3. Email: FNSCIVILRIGHTSCOMPLAINTS@USDA.gov

This institution is an equal opportunity provider.

To file a complaint through HCA 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 Health Care Authority, 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 HCA is confidential. This information will be given to HCA 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.

HCA 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. (4/29/2024)

4. Child Support Services Division

By accepting cash or medical assistance, you assign (give) HCA rights to collect child support from the child's absent parent(s). You must help HCA 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 Services Division (CSSD) 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+
  - Illness
  - Transportation
  - Bad Weather
  - Caring for others
  - Lives too far from Office
  - Working 20 or more hours/week
  - Caring for a child under age 6
  - Other Hardships, please talk to ISD

6. Proof of Information

HCA 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 HCA cannot verify your income and other information through electronic data sources, then HCA 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 HCA, 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 HCA's responsibility to help you, however it is your responsibility to provide the verification.

Verification of:	SNAP/ Food	Medical			Cash	Energy/ LIHEAP	Examples of Proof You May Be Asked To Give HCA
		Family/ Adult	Child Only	Elderly/ Disabled			
Where you live	X	X	X	X	X	X	Utility bill, agreement, letter addressed to you at your address
Social Security Number							Social Security card or letter from the Social Security Administration with your name and number.
Identity	X			X	X	X	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. The Medicaid program will require specific identification proof.
Relationship					X		
Age			X		X		
Immigrant Status	X	X	X	X	X	X	If you are an immigrant applying for assistance, you may have to provide original USCIS (formerly the INS) records.
U.S. Citizenship		X	X	X			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 or Legal Permanent Status. Original documents will be copied and returned. **Proof of Citizenship and ID**: Passport; Certificate of Naturalization - (Form 550 or N-570). **Proof of Citizenship Alone**: US Birth Certificate - If you were born in New Mexico, HCA may be able to help you by checking with the Department of

							Certificate of US Citizenship - (N-560 or N-561) Certificate of Indian Blood (CIB	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.
Disability				X	X	X	Medical records that say how long you will be disabled, whether or not you can work, and if constant help/care is needed.	
Pregnancy	X	X	X	X	X	X	Medical records that say when your baby is due	
School Attendance							Current report card or letter from the school saying whether your child is attending school	
College Student	X				X		Letter from the college saying that you are either a part-time or full-time student	
Student Financial Aid	X				X	X	Letter from the financial aid office stating what types and amounts of financial aid you get and the costs you will have to pay for your schooling	
Income Most recent 30-day period or all from last month	X	X	X	X	X	X	**Earned Income:** Check-stubs, a letter from the employer with the hours you will work and the pay you will get. If you are self-employed, you may give your caseworker a copy of your income tax forms, business records or personal wage records. **Unearned Income:** Copies of your check, or a letter from Social Security, Unemployment Compensation, Worker's Compensation, Veterans Administration, Bureau of Indian Affairs, Public Employees Retirement etc. Alternative Verification may be accepted; please talk to your caseworker.	
Loss of a Job (60 days)	X	X	X	X	X	X	Letter from the employer	
Value of Things You Own				X			Resources/Assets: Recent bank statement or letter of value	
Things You Transferred	X			X	X		Recent statement or letter of value	
Medicare Part A				X			ID card or letter from Social Security Administration	
Child Support Paid	X						If you want a deduction for child support you pay, give proof of both the legal responsibility to pay and the amount paid. Any court or administrative order, or legal separation agreement may be used. For proof of the amount, use cancelled checks, wage withholding statements, verification of withholding from unemployment compensation or written statements from the custodial parent.	

Optional Proof – Below is a list of optional proof items that may help you 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 HCA's responsibility to help you, providing you are cooperating.

Child/Adult Care Costs	X						You may give any of these if they prove your out-of-pocket costs: Agreement, computer printout, money order, letter from the person you pay, divorce or separation papers, statements, receipts, canceled check, copy of a check.
Medical Costs Elderly and Disabled only	X			X			
Home Rent/Owner Costs	X						
Heating/Cooling Costs	X					X	

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 – US Citizen	2 – Lawful Permanent Resident (LPR/Green Card Holder)	3 – Asylee	4 – Refugee	5 – Cuban/Haitian Entrant	6 – Paroled into the US (for at least one year)
7 – Conditional entrant granted before 1980	8 - Battered spouse, child, or parent or un-remarried surviving spouse	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 – Individual with non-immigrant status	14 – Paroled into the US (for less than one year)	15 – Temporary Protected Status (TPS)	16 – Deferred Enforced Departure (DED)	17 – Deferred Action Status	18 – Lawful temporary resident (LTR)
19 – Granted an administrative stay or removal by DHS	20 – Granted Withholding of Removal under the Convention Against Torture (CAT)	21 – Resident of American Samoa	22 – Applicant for Special Immigrant Juvenile Status	23 – Applicant for Adjustment to LPR Status with an approved visa petition	24 – Applicant for Victim of trafficking visa
25 – Applicant for Asylum (with EAD or under age 14 with application pending for at least 180 days)	26 – Applicant Withholding of Deportation or Withholding of Removal (with EAD or under age 14 with application pending for at least 180 days)	27 – Registry applicant (with EAD)	28 – Order of supervision (with EAD)	29 – Applicant for Cancellation of Removal or Suspension of Deportation (with EAD)	30 – Applicant for Legalization under IRCA (with EAD)

31 – Applicant for Temporary Protected Status (TPS)	32 – Legalization under the LIFE Act (with EAD)	33 – Amerasian	34 – Hmong/Laotian
35 – Compacts of Free Association (COFA) citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau Individuals who lawfully reside in the U.S. in accordance with section 141 of the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.	36 – Lawfully Present but not listed	37 – Other	38 – 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 HCA use my SSN? - To 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 HCA, in other governmental agencies. HCA 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 HCA, 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 would I have good cause for not applying for an SSN? - Applicants without SSNs must apply for one before receiving benefits unless there is "good cause."[7C.F.R. § 273.6] "Good cause" means that the person tried to apply for a SSN but cannot, yet.[7C.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?

- **SNAP/Food** – No later than 30 calendar days after the date of application, or expedited SNAP/Food - 7 calendar days. If you do not get SNAP within 7 days, you have a right to ask for an informal conference to see why you were not given expedite food benefits.
- **Medicaid** – Most Medicaid applications must be processed no later than 45 calendar days after the date of application. If a disability determination is required by the Disability Determination Unit (DDU), then HCA has up to 90 days to process your application.
- **Cash** – No later than 30 calendar days after the date of application, or up to 90 days for General Assistance disability decisions
- **Energy/LIHEAP** – No later than 30 calendar days after the date of application, or shut-off/disconnect crisis – 48 hours

(b) If I disagree with the eligibility decision or benefit level, can I have fair hearing?

Yes - If you don't agree with a decision we make about your case, you can ask for a fair hearing in person, by telephone 1-800-432-6217 or (505) 827-8164, or in writing within 90-days of the date that a notice has been sent informing you of any action that has been taken on your case. Please mail your request to the HCA Office of Fair Hearings at PO Box 2348 Santa Fe, NM 87504. You have a right to look at your case file and any records HCA used to determine your eligibility before your hearing. You can ask a household member or someone else like a friend or relative to represent your household at the fair hearing. You also have the right to have an attorney or other legal representative at the hearing.

(c) From what date are my benefits calculated?

- **SNAP/Food** – From the date you applied
- **Energy/LIHEAP** – On the date HCA verifies your account with your energy provider
- **Cash** – On the date HCA approves your application or the 30th day from the date of application, whichever is earlier
- **Medicaid** – If you are approved, you will receive Medicaid from the first day of the month you applied. You may be eligible for up to 3 prior months of Medicaid coverage.

(d) How will I get my benefits?

- **Medicaid** - A Medicaid card will be mailed to you by your managed care organization (MCO) within 20 days of approval. If you do not have an MCO, then HCA will mail you a card. Your doctor can look up your Medicaid before you receive a card in the mail. You can receive covered services as soon as you are approved. Call your MCO to find out about covered services. If you do not have an MCO, call HCA at 1-800-283-4465
- **Energy/LIHEAP** - Your payment will be sent directly to your energy provider 7-days from the date HCA verifies your account information with your energy provider. For a shut-off/disconnect crisis, HCA will call your energy provider to help you avoid shut-off.
- **SNAP/Food and Cash** - HCA uses an electronic debit card system called EBT to give you your cash and SNAP/food assistance benefits. If you have never had an EBT card, an EBT card will be mailed to your address in one working day after the date you apply and after your application is registered on the computer. If your EBT card is delayed, you may request a card from your local ISD office. You may call EBT Customer Service 24 hours 7- days/week at 1-800-843-8303 to order a replacement or activate your EBT card.

Each month your cash benefit will be deposited in your EBT account on the first day of the month. Your SNAP/food benefits will be deposited in your EBT account on the day of the month in the box below that lists the last two digits of the head of household's social security number.

Combined Schedule: If you have applied for SNAP/Food assistance after the 15th day of any month and are approved for expedited assistance, you will receive your benefits according to the schedule below.

- You will receive your 1st and 2nd month's benefits the day your case is approved.
- You will receive your 3rd month's benefits on the 1st day of the month.
- You will receive your 4th month's benefits within the first 10 days of the month, depending on the last two digits of your SSN.
- You will receive your 5th month's benefits within the first 20 days of the month, depending on the last two digits of your SSN. This will be your regular day of the month to receive your future SNAP/Food Stamp benefit.

SNAP/Food Assistance *Compressed Staggered* Issuance Schedule																			
Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN
	11		01		12		02		13		03		14		04		15		05
	31		21		32		22		33		23		34		24		35		25
	51		41		52		42		53		43		54		44		55		45
	71		61		72		62		73		63		74		64		75		65
1	91	**2**	81	**3**	92	**4**	82	**5**	93	**6**	83	**7**	94	**8**	84	**9**	95	**10**	85
	16		06		17		07		18		08		19		09		10		00
	36		26		37		27		38		28		39		29		30		20
	56		46		57		47		58		48		59		49		50		40
	76		66		77		67		78		68		79		69		70		60
	96		86		97		87		98		88		99		89		90		80

SNAP/Food Assistance *Staggered* Issuance Schedule																			
Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN	Day	SSN
	11		01		12		02		13		03		14		04		15		05
	31		21		32		22		33		23		34		24		35		25
1	51	2	41	3	52	4	42	5	53	6	43	7	54	8	44	9	55	10	45
	71		61		72		62		73		63		74		64		75		65
	91		81		92		82		93		83		94		84		95		85
	16		06		17		07		18		08		19		09		10		00
	36		26		37		27		38		28		39		29		30		20
11	56	12	46	13	57	14	47	15	58	16	48	17	59	18	49	19	50	20	40
	76		66		77		67		78		68		79		69		70		60
	96		86		97		87		98		88		99		89		90		80

(e) How long can I get benefits before I have to renew them?

- **SNAP/food** – Up to 12 months is typical or 36 months for elderly/disabled households with no earned income
- **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-monthlimit 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 <u>address changes</u> 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:
    - The change(s) will cause your case to close; or
    - 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:
    - Living arrangements or change of address: Report any change in where an eligible recipient lives or gets mail.
    - 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.
    - Enumeration: Report any new social security number of individuals receiving Medicaid benefits in the household, including any newborn receiving Medicaid.
    - 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.
    - 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: **1st Sanction – 25%cash reduction; 2nd – 50% cash reduction; and the 3rd – Case Closure.** When you meet any of the following situations, you may be able to receive different work activities or less hours if any of the following apply to you:

▪ Single Parent Caring for a Child under 12 Months Old – 1 lifetime limit	▪ Temporary Personal Situations – Up to 30 days
▪ Age 60 or Older	▪ Disabled
▪ Pregnant in Third Trimester or Six weeks post-partum	▪ Caring for 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 links below, you will find resource listings available throughout New Mexico. You will find the resource listings by county.
  https://hca.nm.gov/lookingforassistance/field_offices_ https://yesnmconnect.nm.gov/

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 Health Care Authority, 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, 8:00 am to 5:00 pm. If you have any questions regarding the EBT card procedure, please call 1-800-283-4465.

(d) I lost my card.
If you have received SNAP/Food or Cash assistance in the past and your EBT card does not work, please call the EBT contractor Service Desk at 1-800-843-8303 or 1-800-283-4465. Your new EBT card will be mailed to you on the first working day after you request one from the EBT contractor Customer Service Desk.
You should receive your EBT card within 7 days of date of applying. If 7 days have passed, and you have not received your card, please contact the EBT Help Desk at 1-800-283-4465 so arrangements can be made for you to pick up a card at the local county ISD office.
You must activate your card when you get it. You need to get a Personal Identification Number (PIN) from the EBT contractor. To activate your card and get a PIN, please call 1-800- 843-8303- 24 hours a day or 1-800-283-4465, Monday-Friday, 8:00am to 5:00pm. If you have any questions regarding the EBT card procedure, please call 1-800-283-4465.

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

In what situations can you ask for a fair hearing? ►	■ You disagree with a decision on your case, or	■ You believe your benefits were not calculated correctly, or
	■ You apply for benefits and are denied, or	■ A change was made that you do not agree with.

How long do you have to ask for a 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 your 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 HCA 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 HCA decided your case. You do not have a right to a fair hearing if HCA'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 HCA office, or Customer Service Center at 1-800-283-4465

- Write HCA's Office of Fair Hearing at HCA, 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 1-833-862-3935 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, HCA or the NMHIX will send you a letter telling you the date, time and place where your hearing will be held. HCA hearings are usually at the ISD office. The hearing will be conducted by a hearing officer from the HCA 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 HCA 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 HCA 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 4/29/2024)

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 two 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:

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PERSONAL INFORMATION — This information not to be copied.

1 NAME: Last | First | Middle Name or Initial | Gender | Birth Date | Social Security Number

2 **PHYSICAL STREET ADDRESS WHERE YOU LIVE NOW**
Street Address | Apartment, Unit, or Lot # | City | Zip

3 **ADDRESS WHERE YOU GET YOUR MAIL (If different from above)**
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.

DAYTIME TELEPHONE NUMBER (optional)

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

POLL WORKER

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

8 **I hereby authorize you to cancel my previous registration in the following county and state.** City or Township | County | State

9 Please answer the following questions:

Are you a citizen of the United States? YES NO

Will you be 18 years of age on or before the next general election? YES NO

If you checked "NO" to any of the questions above, do not complete this form.

If you have been convicted of a felony and are currently on parole or supervised probation do not complete this form

ATTESTATION OF QUALIFICATION

I swear/affirm that I am a citizen of the United States and a resident of the state of New Mexico; that I have not been denied the right to vote by a court of law by reason of mental incapacity; that I am, or will be at the time of next election, 18 years of age; and, if I have been convicted of a felony, I have completed all conditions of parole and supervised probation, served the entirety of a sentence or have been granted a pardon by the governor. I further swear/affirm that I am authorizing cancellation of any prior registration to vote in the jurisdiction of my prior residence; and that all information I have provided is correct.

SIGN YOUR FULL NAME OR MARK ON THE LINE BELOW:

TODAY'S DATE Month / Day / Year

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

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.

SP&G-1 (2015)

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.

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

MAP

N
W + E
S

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If you, or someone you are helping, have questions about applying for assistance or need help applying, you have the right to get information and help in your language at no cost. To speak with an interpreter, call (800) 283-4465 {language specific extension.}

Spanish Si usted, o alguien a quien está ayudando, tiene preguntas sobre cómo solicitar asistencia o necesita ayuda para solicitarla, tiene derecho a obtener información y ayuda en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 283-4465 Español, presione 2.	Navajo T'áá ni ádá, éí doodago, t'áá háida bíká anilyeedígíí, naaltsoos hadilnéehgi bína'ídíkid hólǫ́go da éí doodai' ła' níká adoolwołígíí yíníkeedgo, ná bá haz'á̧ dóó t'áá jíík'eh t'áá Dinék'ehjí nił náhane'go bíighah. Atxa' halne'í bił ahił hodíílnihgo éí, koj̨' hodíílnih (800) 283-4465, ashdla' (5) bił yaa adidíílchił, áádóó bik'ij̨' táá' (3) nááná.
Tagalog Kung ikaw o ang taong iyong tinutulungan ay may mga katanungan tungkol sa pag aapplay ng tulong o kailangan mo ng tulong sa pag aaplay meron kang karapatan na makakuha ng impormasyon at tulong sa inyong sariling wika ng walang binabayaran. Para maka usap ang Tagasalin tumawag sa (800) 283-4465 Tagalog, pindutin ang 5 tapos 9 at 4.	Korean 본인 또는 도움을 주는 사람이 지원 신청에 대한 질문이 있거나 신청과 관련하여 도움이 필요한 경우, 귀하는 무료로 모국어를 통해 정보와 도움을 받을 수 있는 권리가 있습니다. 통역사와 대화하려면(800) 283-4465으로 전화하시고, 한국어는 5, 8번을 눌러주십시오.
Vietnamese Nếu bạn hoặc ai đó mà bạn đang giúp đỡ cần hỏi về quy trình làm đơn xin trợ giúp hoặc cần được giúp làm đơn, thì bạn có quyền được nhận thông tin và trợ giúp miễn phí bằng ngôn ngữ của mình. Để nói chuyện với thông dịch viên, hãy gọi số (800) 283-4465, ấn phím 3 để chọn tiếng Việt.	Thai หากท่านหรือคนที่ท่านกำลังช่วยเหลือมีคำถามเกี่ยวกับการสมัครขอความช่วยเหลือหรือตอ้ งการความช่วยเหลือในการสมัคร ท่านมีสิทธิ์ที่จะไดร้ ับขอ้ มูลและความช่วยเหลือเป็นภาษาของท่านโดยไม่มีค่าใชจ้ ่าย หากตอ้ งการคุยกับล่ามโทร (800) 283-4465 ภาษาไทย กด 5 แลวก็ 9 แลวก็ 7
Simplified Chinese 如果您本人或者您正在帮助的某人对申请援助存在疑问或者需要获得申请帮助，您有权免费获得以您所用语言提供的信息和帮助。如需与口译员交谈，请拨打(800) 283-4465，普通话，请按4。	Japanese あなた、またはあなたがサポートしている方が、支援の申請について質問がある場合、または申請のサポートが必要な場合は、ご自身の母国語による情報とサポートを無料で受ける権利があります。通訳をご希望の場合は、(800) 283-4465にご連絡ください。日本語は「5」を押してから「6」を押してください。
Traditional Chinese 如果您本人或者您正在幫助的某人對申請援助存在疑問或者需要獲得申請幫助，您有權免費獲得以您所用語言提供的信息和幫助。 如需與口譯員交談，請撥打(800) 283-4465，廣東話，請按5。	French Si vous, ou quelqu'un que vous aidez, avez des questions concernant la demande d'aide ou avez besoin d'aide pour faire une demande, vous avez le droit d'obtenir gratuitement des informations et de l'aide dans votre langue. Pour parler à un interprète, appelez le (800) 283-4465 français, appuyez sur 5, puis 9, puis 5.

Swahili	Russian
Ikiwa wewe, au mtu mwingine unayemsaidia, ana maswali kuhusu kutuma ombi la usaidizi au anahitaji kusaidia kutuma ombi, una haki ya kupata taarifa na usaidizi kwa lugha yako bila malipo. Ili kuzungumza na mkalimani, piga simu (800) 283-4465 kwa Kiswahili, bonyeza 5, kisha 4	Если у вас или у того, кому вы помогаете, есть вопросы о подаче заявления на получение помощи или вам нужна помощь в подаче заявления, вы имеете право получить информацию и помощь на вашем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру (800) 283-4465 на русском языке, нажмите 5, затем 9, затем 3.
Arabic	Pashto
إذا كانت لديك، أو لدى شخص تساعده، أسئلة حول التقدّم بطلب للحصول على المساعدة أو تحتاج إلى مساعدة في تقديم الطلب، فمن حقك الحصول على المعلومات والمساعدة بلغتك دون أي تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم (800) 283-4465.2 ثم اضغط 5 ثم	که تاسو، یا هغه څوک چې تاسو ورسره مرسته کوی د مرستې لپاره د خواست کولو په اړه پوښتنې ولری یا خواست کولو لپاره د مرستې اړتیا ولری، تاسو حق لری معلومات او مرسته پخپله ژبه کې په وړیا توګه (پرته د کوم لګښت) تر لاسه کړی. د یو ترجمان (ژباړونکي) سره د خبرو کولو لپاره، (800) 283-4465 ته زنګ ووهئ، 5 کښې کاږئ، بیا 9، بیا 8.
Dari	Persian/Farsi
اگر شما یا شخص که به او کمک می‌کنید، درباره تقاضای مساعدت سؤالات دارید یا برای تقاضانامه به مساعدت ضرورت دارید، حق دارید بدون کدام مصرف معلومات و مساعدت را به لسان خود را دریافت کنید. برای صحبت با ترجمان، با (800) 283-4465 دری/هسپانوی در تماس شوید، 5 را فشار دهید و سپس 5 را فشار دهید.	اگر شما یا فردی که به او کمک می کنید، درباره ارائه درخواست کمک پرسشی دارید یا برای درخواست دادن به کمک نیاز دارید، می توانید به طور رایگان اطلاعات و کمک هایی را به زبان خود دریافت کنید. برای صحبت با یک مترجم شفاهی، با شماره (800) 283-4465 تماس بگیرید و برای فارسی عدد 5 و سپس 7 را فشار دهید.
Gujarati	Hindi
જો તમને, અથવા તમે જેમને મદદ કરી રહ્યા છો તે વ્યક્તિને, સહાય માટે અરજી કરવાની પ્રક્રિયા અંગે કોઈ પ્રશ્નો હોય અથવા અરજી કરવા માટે મદદની જરૂર હોય, તો તમને કોઈપણ ખર્ચ વિના તમારી ભાષામાં માહિતી મેળવવાનો અને સહાય મેળવવાનો સંપૂર્ણ અધિકાર છે. દ્વિભાષિયા સાથે વાત કરવા માટે (800) 283-4465 પર કોલ કરો, પછી 9 દબાવો અને ત્યારબાદ 5 દબાવો.	अगर आप या आपकी मदद से कोई सहायता के लिए आवेदन कर रहा है और आपको आवेदन से जुड़ी जानकारी या मदद चाहिए, तो आप यह सहायता अपनी भाषा में, बिना किसी शुल्क के पा सकते हैं। भाषा सहायता प्रतिनिधि (इंटरप्रेटर) से बात करने के लिए (800) 283-4465 पर कॉल करें और पहले 9, फिर 6 दबाएँ।
Lao	
ຖ້າທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບການສະໝັກຂໍການຊ່ວຍເຫຼືອ ຫຼື ຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການສະໝັກ, ທ່ານມີສິດຮັບຂໍ້ມູນ ແລະ ການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍໃດໆ. ເພື່ອລົມກັບລ່າມແປພາສາ, ກະລຸນາໂທຫາ (800) 283-4465, ກົດ 9 ແລ້ວຕາມດ້ວຍ 5.	