CHRISTUS Southern New Mexico

Application for Financial Assistance: Patient Account Number(s):_____

Important: You may be able to receive financial assistance to pay for your care. Completing this application will help CHRISTUS Southern New Mexico determine if you are eligible for our Financial Assistance Programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for financial assistance within 120 days following the date of discharge or receipt of your care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.						
PATIENT INFORMATION						
Email Address						FAMILY SIZE
Last Name		First	M.I.	Date of Birth	Social Security Number	
Street	Apt. #	City	State	Zip Code		Home Phone
Employer		Address				Cell Phone
City	State	Zip Code		Monthly Income		Work Phone
GUARANTOR / (SPOUSE IF RESPONSIBLE PARTY, PARENT IF MINOR)					Relationship to Patient	Date of Birth
Email Address						
Last Name		First	M.I.			Home Phone
Employer		Address				Cell Phone
City	State	Zip Code		Monthly Income		Work Phone

Presumptive Eligibility: Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria listed below individually or through the benefits provided to their Family may be eligible to receive financial assistance.

Check as many as apply:

- ☐ PERSONAL BANKRUPTCY
- ☐ DECEASED WITH NO ESTATE
- ☐ MEDICAID ELIGIBILITY, BUT NOT ON THE DATE OF SERVICE OR FOR NON-COVERED SERVICE
- ☐ INCARCERATED
- ☐ HOMELESSNESS
- ☐ OTHER

Income Information

Please provide one or more of the following for each employed family member and sign the statement below.

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1. a copy of most recent tax return (W-2 and 1099 Forms)
2. a copy of last 3 months bank statements
3. a copy of last 3 months pay stubs
4. a copy of last 3 months statement from your employer if paid in cash
5. any other verification from a third party about your income for the last 3 months

You may receive income or support from another source for example unemployment compensation, capital gains or losses, workers' compensation, Social Security, Supplemental Social Security, public assistance, Veterans payments, survivors benefits, pension or retirement income, interest, dividends, rent, royalties, estate income, distribution from estates, inheritance, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Please indicate the source and amount ofincome

Income Source	Amount
	-

If you cannot provide any documentation relating to your income, fill out the statement below:

I,_____(name), certify that I have no documents that prove my family's monthly income is $_____.

Dependent Household Members

Name	Age	Relationship

Other information

If you have additional documents that may help Advocate make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, bank or checking statements, etc.)

APPLICANT CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Applicant Signature:_____Date: _____

If you have submitted an application for financial assistance in the past 120 days and would like to know the status of your application please call the Financial Services office at the hospital.

You may return your completed application and documents by mail to CHRISTUS Southern New Mexico; 2669 Scenic Drive; Alamogordo, NM 88310. For additional questions please contact the Patient Financial Services Department at 575-443-7402 between the hours of 8:00 a.m. and 5:00 p.m.