



Did the patient/ or head of household file a Federal / State Income Tax Return last year? *¿Usted completo formas de impuestos sobre los ingresos al gobierno Federal y del Estado?* Yes/ Si \_\_\_ No \_\_\_ (Earned/ or Unearned Income/ Ingresos Percibidos)  
\*\* If you were exempt from filing provide proof. / Si usted esta exonerado traiga prueba.

### 5. Other Insurance or Liability/ Seguro de responsabilidad

Reason for medical treatment? *¿Porque razón fue el tratamiento?* (CHECK ONE ) (PONGA MARCA )  
Personal injury/Daño personal \_\_\_ Motor vehicle accident/ Accidente de automóvil (provide police report/ consigne el reporte de policia) \_\_\_ Work Related injury/ Daño en el trabajo \_\_\_ Illness/Enfermedad \_\_\_  
Pregnancy/Embarazo \_\_\_ OTHER/Otra razón \_\_\_ Explain/ Explique: \_\_\_\_\_

Are there any liability claims or legal action pending as a result of this hospitalization? *¿ Hay reclamos legales debido ha este servicio medico?* Yes/ Si \_\_\_ No \_\_\_  
Explain/ Explique: \_\_\_\_\_

### 6. Medical Coverage/ Cubertura medical

Is there any medical coverage for the family? *¿Hay seguro medico para la familia?* Yes/Si \_\_\_ No \_\_\_  
For the patient? *¿ Para el paciente?* Yes/Si \_\_\_ No \_\_\_ N/A(No aplica) \_\_\_

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

Does the patient or any other member of the household have medicaid/medicare? *¿Hay seguro medico para el paciente o otro miembro del hogar de medicaid/medicare?* Yes/Si \_\_\_ No \_\_\_

Medical coverage for the pregnancy related services? *¿Seguro medico para el embarazo?* Yes/Si \_\_\_ No \_\_\_  
If so, name of program/ Si tiene cubiertura ponga el programa: \_\_\_\_\_  
Date of delivery/ Fecha de su parto: \_\_\_\_\_ Has the patient been referred to apply for EMSA? *¿El paciente ha aplicado para el servicio médico de emergencia?* Yes/Si \_\_\_ No \_\_\_ N/A (No aplica) \_\_\_

### 7. Public Assistance/Otro tipo de asistencia publica

(CHECK ONE ) (PONGA MARCA )  
Has the patient or anyone else within the household recently applied for the following? *¿El paciente o otro miembro del hogar han aplicado para lo siguiente?* SSI/SSA(Disability/ Encapacitado) \_\_\_ Welfare(aka TANF) \_\_\_  
Date Filed/ Fecha de registro: \_\_\_\_\_ Status/ Situación: \_\_\_\_\_  
Person that applied/ Persona que aplico: \_\_\_\_\_  
Explain if necessary/ Explique la situación: \_\_\_\_\_

### 8. Assets/Recursos o bienes

(GIVE VALUE)

(PONGA EL VALOR)

(Provide ALL proof of any investments or other properties owned by the applicant/patient or household unit as follows/ Prueba de TODOS inversiones o propiedades propio para el aplicante/paciente o el establecimiento doméstico:)

Personal Home/ Casa propia (valor de su propiedad) \$ \_\_\_\_\_ Escrow Account/ Cuenta en custodia de tercera persona \$ (Equity/ Equidad) \$ \_\_\_\_\_ Stocks or bonds/ Otras inversiones \$ \_\_\_\_\_ Checking Accounts/ Cuenta de cheque \$ \_\_\_\_\_ Savings Account/ Cuenta de ahorro \$ \_\_\_\_\_ Investments/ Inversiones \$ \_\_\_\_\_

If the patient is deceased, was there a life insurance? *¿Si el paciente falleció usted recibió compensación de seguro?* Yes/Si \_\_\_ No \_\_\_ Full Value/ Valor Completo \$ \_\_\_\_\_ (Explain how excess proceeds were spent on comments of this application/ Explique como uso los ganancias de exceso en el comentarios de esta aplicación)

8.A Have you sold any property(s) in the past year? *¿Usted ha vendido propiedad en el ultimo año?* Yes/Si \_\_\_ No \_\_\_  
Income from Sale/ Ingresos de venta \$ \_\_\_\_\_

### 9. Debts/Deudas

Do you receive other monies from a friend or relative to compensate your monthly expenses? *¿Usted recibe otra ayuda monetaria de un amigo(a) o familiar para compensar sus deudas que paga mensual?* Yes/Si \_\_\_ No \_\_\_  
Amount/ Cantidad \$ \_\_\_\_\_ (Provide proof/ Traiga prueba)

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EDDY COUNTY HEALTH CARE SERVICES

PROOF OF RESIDENCY

The Indigent Hospital/Health Care Services Request verification of residency for \_\_\_\_\_ Please provide the following information:  
(Applicant's Name)

I verify that this individual has lived in Eddy County for the past \_\_\_\_\_ months/years.  
I declare that I am not related to this individual.  
I hereby state that this person resides at:

\_\_\_\_\_ located in \_\_\_\_\_  
(Street Address) (City/Town)

The above mentioned individual has lived at the above address from \_\_\_\_\_ to \_\_\_\_\_  
(Month/Year) (Month/Year)

Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_ My Commission Expires: \_\_\_\_\_  
Notary Public

EDDY COUNTY  
INDIGENT HOSPITAL AND COUNTY HEALTH CARE  
101 W. GREENE ST., SUITE 225  
CARLSBAD, NM 88220  
505-887-9511  
FAX 505-887-1039

UNEMPLOYMENT VERIFICATION

Date: \_\_\_\_\_

To: EDDY COUNTY INDIGENT HOSPITAL AND COUNTY HEALTH CARE

I, \_\_\_\_\_, certify that I am not presently employed. I  
have been unemployed since \_\_\_\_\_ and I am/am not (please  
circle one), presently receiving unemployment benefits. My last employer was

\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

Subscribed and Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_,  
20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:

\_\_\_\_\_

EDDY COUNTY  
INDIGENT HOSPITAL AND COUNTY HEALTH CARE  
101 W. GREENE STREET, SUITE 225  
CARLSBAD, NM 88220  
575-887-9511 EX: 2601 OR 2602  
FAX 575-628-3871

EMPLOYMENT VERIFICATION FORM  
(To be completed and signed by the employer)

Date \_\_\_\_\_

This is to verify that \_\_\_\_\_ is employed at \_\_\_\_\_.

Date of Hire was \_\_\_\_\_. Hours per week average about \_\_\_\_\_. Pay is \_\_\_\_\_

Per hour. Or is on salary of \$ \_\_\_\_\_. Does/Does not receive tips at an average  
of \_\_\_\_\_.

Pay Periods are weekly, biweekly, monthly, semi-monthly, and checks are Received on  
\_\_\_\_\_. The first check will be received on \_\_\_\_\_.

Signature of Authorized Personnel \_\_\_\_\_ Title \_\_\_\_\_

TAX WAIVER

This statement certifies that I am not required to file a federal nor state tax return for the year of \_\_\_\_ . I understand that I am knowingly providing this information and declare that this information is true and correct under penalty that any false statements made knowingly shall constitute a felony.

\_\_\_\_\_  
Patient or Claimant Signature\*

\_\_\_\_\_  
Spouse (for Joint Return)

SUBSCRIBED AND SWORN TO before me this \_\_\_\_ day of \_\_\_\_\_  
20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

SEAL

\* If patient is a minor child, signature must be from a parent, guardian, or custodial representative.