

**Fort Bayard Medical Center  
41 Fort Bayard Road  
Santa Clara, NM. 88026**

**Financial Disclosure Statement**

Name: \_\_\_\_\_ Social Security: \_\_\_\_\_

Spouse's Name (if applicable): \_\_\_\_\_ Social Security: \_\_\_\_\_

Do you own or have interest in property other than the property which is the primary residence of spouse or dependent children? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Monthly Income (Pensions, Rental Income, Annuities, Social Security, Interest Income, etc.):**

Source	Applicant	Spouse
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

If there is a retirement pension please list name of Group as well as their address and phone number:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Bank Accounts (CD's, Stocks and Bonds)**

Bank Name, Address & Zip Code	Type of Account	Account Balance
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

**Certification**

The Department of Health and Fort Bayard Medical Center are authorized to investigate the financial information provided by applicants or their representative(s) to determine their ability to pay for services. Any applicant or representative(s) who knowingly withholds or falsifies financial information shall be liable for all expenses incurred for legal action related to the recovery of valid indebtedness to the State of New Mexico.

I hereby certify that the foregoing information is true and correct to the best of my knowledge and belief. I agree to report any change in income to the Financial Specialist of Fort Bayard Medical Center.

\_\_\_\_\_  
Name of Person Completing Information (Please Print)

\_\_\_\_\_  
Signature of Person Completing Information

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relation to Applicant if other than Applicant