NEW MEXICO HIV SERVICES
ACCESS RECERTIFICATION FORM

Part A - General

First: _____ Middle: _____ Last: _____

SSN: _____ DOB: _____

Home Address: _____ Mail: □ Yes □ No

City: _____ State: _____ Zip: _____ County: _____

Mailing Address: _____ Mail: □ Yes □No

City: _____ State: _____ Zip: _____

Home Phone: OK to call: _____ □Yes □No Message OK: □Yes □No

Work Phone: OK to call: _____ □Yes □No Message OK: □Yes □No

Cell Phone: OK to call: _____ □Yes □No Message OK: □Yes □No

Part B - Financial

A copy of one of the following documents is required to verify financial status:

Employed: If you have employment earnings submit your three most current consecutive check stubs.

Self-Employed: If you have personal business earnings submit copies of CRS documents submitted to NM Tax & Revenue for the one year period immediately prior to date of application.

No Income: Submit a statement of no income and a signed statement of support from the individual who assists you with essential costs of living (valid for six months).

Social Security Benefits: If you are receiving SS Benefits, submit a current award letter.

-Food stamps & student loans are NOT considered income-

Number of Dependents in Household (including applicant) _____

Note: See program policies for definition of household dependents.

Monthly Income: (Enter zero if none):

Employment (indicate frequency)	$_____	Trust Fund/Stock/Properties	$ _____
Unemployment	$ _____	General Assistance/TANF	$ _____
Retirement/Private Disability	$ _____	SSDI	$ _____
Spousal Income	$ _____	SSI	$ _____

Medical Payer Sources (check all that apply):

□ **Private:** □ **Other Public:** □**NMMIP** □**VA** □**Champus**

□ **COBRA:** □ **Medicare:** □**A** □**B** □**A&B** □ **Medicare D:** **Low Income Subsidy:** □**Yes** □**No**

□ **Medicaid:** □ **Medicaid Not on File: Verified by/date:** / Audit #: _____

□ **Tricare** □ **IHS** □ **No Insurance** □ **Other** _____

Company Name: _____ Member ID#: _____ Effective date: _____

Outpatient Drug Benefits: □Yes □No **Effective date:** _____

□ **Dental Company** _____

By signing this form, I hereby authorize an **Exchange of Information** concerning my history, care and treatment between HMA staff, the Department of Health, medical care programs, caseworkers, funding sources, and those involved in the provision of physical and/or psychological care and financial support. I have read, understand, and agree to all the statements made on all parts of this application. All statements are true to the best of my knowledge. I agree to inform the HMA within one month of any changes. I further agree to abide by the Client Rights & Responsibilities as they have been explained to me.

Client Name (first, last) Client Signature Date

Case Manager (Print first, last/Sign) Phone Date