Ruidoso Hospice Foundation

APPLICATION

NAME:_____ Date of Birth: _____

SSN: _____ Phone: _____

Physical Address:_____

Mailing Address: _____

Check one:

____Own ____Rent ____Share rent ____Supplied free of charge ____Homeless

List prior physical residence if less than 1 year at the current address:_____

_____

List all members in the home (use second page if necessary):

Full Name	DOB	SSN	Relationship to Applicant

INCOME (Received in the past 12 months):

Employer:	Gross Amount Received: $
Employer:	Gross Amount Received: $
Unemployment: $	Welfare (aka TANF): $
Food Stamps: $	SSA/SSI Benefits: $
VA: $	Pension: $
Workman's Comp: $	General Assistance: $
Other Income not listed: $	Other Income not listed: $

- If you are employed this year provide current check stubs verifying type of income earned for all employment.
- Did the Applicant or Head of Household file a Federal/State Income Tax Return last year: ___Yes ___No ***If you were exempt from filing, provide proof.*

MEDICAL COVERAGE / INSURANCE

Does the Applicant have medical coverage? ____Yes ____No

Name of Insurance:_____ (include a copy of insurance card)

Does Applicant have: ____Medicare ____Medicaid (include copy of card(s)

Does Applicant have: ____Medicare Part D (include copy of Rx card)

ASSETS (Give value):
Provide proof of any investments or other properties owned by the Applicant or household unit:

Personal Home $_____ Escrow Account $_____
Stocks / Bonds $ _____ Investments $_____
Checking Account $_____ Savings Account $_____

Do you receive other monies from a friend/relative to compensate your monthly expenses?

- Have you filed an application with the Lincoln County Indigent Fund for assistance with medical bills within the past 12 months? _____Yes _____No
- If yes, may we contact the Lincoln County Indigent Fund Administrator to confirm your application and eligibility? _____Yes _____No

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REQUESTING ASSISTANCE FOR:

____Home Health services related to end of life care not covered by insurance, Medicare, Medicaid, etc., including medications and medical equipment. ($2500 max per year)

____Hospice services not covered by insurance, Medicare, Medicaid, etc., including medications and medical equipment. ($5000 max per year)

____Lifeline Systems (includes $25 set up fee, and $30 per month monitoring service)

SIGNATURE OF APPLICANT_____**DATE**_____

To determine your eligibility, the following documentation MUST be provided along with the completed application:

____Copy of Medicare/Medicaid other insurance card)
____Copy of Bank Statements
____Proof of Income (pay stubs and/or copy of Social Security check OR Income Tax Return)
____Tax Waiver (if you are exempt from filing Income Tax)
____Copy of the Prescription Plan Card—Medicare Part D
____Copy of a **3-month old** utility bill (this provides proof of residency)

You will be notified if your application has been approved or denied.
Upon approval, your receipts must be mailed to:
Ruidoso Hospice Foundation, P.O. Box 555, Ruidoso, NM 88355

For office use only

COMMENTS

_____

_____

Information verified by _____ Date _____

Application: ___Approved ___Denied

By _____ Date_____
Board Member

Date Applicant notified _____ *By Phone*_____ *By Letter* _____ ***Form Revised May 2013***