



MEDICAID APPLICATION FOR
Qualified Medicare Beneficiaries (QMB)
Specified Low Income Medicare Beneficiaries (SLIMB)
Qualified Individuals 1 (QI)
Working Disabled Individuals (WDI)

INFORMATION FOR THE APPLICANT

You may use this application to apply for the above programs. Please complete all the spaces on the application that pertain to you and your household members. If you need more space to answer any of the questions on this application, you may use the back of pages 3 and 4. If you have a spouse who wants to apply for the above programs, she/he also needs to complete an application. Please return the application(s) to the local Income Support Division (ISD) office.

There are other Medicaid programs that require a different application from this one.

If you qualify for one of the above programs, Medicaid will cover the following:

- Under the **QMB** program, you must have or be eligible for Medicare part A (Hospital Insurance). Medicaid will pay your Medicare premiums, deductibles, and co-insurance charges on Medicare covered services only. Medicaid will not cover dental, vision or prescription services.
- Under the **SLIMB** and **QI1** program, you must have Medicare Part A. Medicaid will pay your Medicare Part B (Medical Insurance) premium only.
- Under the **WDI** program, you must be disabled and working, or have lost Supplemental Security Income (SSI) due to initial receipt of Social Security Disability Insurance (SSDI), and do not yet have Medicare. Medicaid will pay for all covered medical services. Small co-payments are required.

After the ISD office receives your application, you will have an interview. You will be asked to provide proof of the information needed to determine your eligibility.

Please see page 2 for YOUR RIGHTS and RESPONSIBILITIES.

APPLICANT:

Please keep this sheet for your records.



If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in **any public hearing, program or services**, please contact the NM Human Services Department toll-free at 1-800-432-6217, or TDD 1-800-609-4TDD or through the New Mexico Relay System TDD at 1-800-659-8331. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (4/23/01)

Register to Vote

HSD Site Code I-01

PERSONAL INFORMATION				This information <i>not</i> to be copied.								
1	NAME Last	First	Middle Name or Initial	Gender	Birth Date	Social Security Number						
PHYSICAL STREET ADDRESS WHERE YOU LIVE NOW												
2	Street Address			Apartment, Unit, or Lot #	City	Zip						
ADDRESS WHERE YOU GET YOUR MAIL (If different from above)												
3	Address			City	Zip							
4	If you are changing your name on this application, under what full name were you previously registered?			Last Name - First Name - Middle Name or Initial								
POLITICAL PARTY				DAYTIME TELEPHONE NUMBER (optional)		POLL WORKER						
5	NOTE: You must name a major political party to vote in primary elections. ▶▶▶	Party	If you choose NO PARTY, check this box: <input type="checkbox"/>	6	May the County Clerk make this telephone number public for election purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO	Would you like to serve as an election day precinct worker? <input type="checkbox"/> YES <input type="checkbox"/> NO						
7	I hereby authorize you to cancel my previous registration in the following county and state.			City or Township	County	State						
Please answer the following questions:				ATTESTATION OF QUALIFICATION								
8	Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No Will you be 18 years of age on or before election day? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked "NO" to any of the questions above, do not complete this form. If you have been convicted of a felony and are currently on parole or supervised probation do not complete this form			I swear/affirm that I am a citizen of the United States and a resident of the state of New Mexico; that I have not been denied the right to vote by a court of law by reason of mental incapacity; that I am, or will be at the time of the next election, 18 years of age; and, if I have been convicted of a felony, I have completed all conditions of parole and supervised probation, served the entirety of a sentence or have been granted a pardon by the governor. I further swear/affirm that I am authorizing cancellation of any prior registration to vote in the jurisdiction of my prior residence, and that all the information I have provided is correct.								
TODAY'S DATE Month Day Year ____/____/____				SIGN YOUR FULL NAME OR MARK ON THE LINE BELOW: _____								
9	Name of agent who assisted you in filling out this form:		VRA ID #		_____							
DO NOT WRITE IN SHADED AREAS - FOR OFFICIAL USE ONLY												
Accepted for filing in County Registration Records					I.D.	PCT.	MUN.	PRC.DIST.	REP.DIST.	SEN.DIST.	SCHOOL	C.C.
Date _____ County Clerk _____ Filing Clerk _____												

NMVR-1 HSD (2012)

Registrarse para Votar

HSD Site Code I-01

INFORMACION PERSONAL				Esta información no se debe copiar.								
1	NOMBRE: Apellido	Su Nombre de Pila	Otro Nombre o Inicial	Género	Fecha de Nacimiento	Número de Seguro Social						
DIRECCION DONDE UD. VIVE AHORA												
2	Número y Nombre de la Calle			Departamento, Unidad o # de Lote	Ciudad	Zona Postal						
DIRECCION DONDE UD. RECIBE SU CORRESPONDENCIA												
3	Dirección			Departamento	Ciudad	Zona Postal						
4	¿Si Ud. va a cambiar su nombre en esta solicitud, bajo que nombre completo estaba Ud. matriculado antes?			Apellido	Nombre de Pila	Otro Nombre o Inicial						
PARTIDO POLITICO				NUMERO DE TELEFONO EN EL DIA (opcional)		EMPLEADO/A EN URNA ELECTORAL						
5	AVISO: Ud. tiene que indicar partido político principal para votar en la elección primaria ▶	Partido	Si Ud. NO ELIGE Partido marque aquí <input type="checkbox"/>	6	¿Con motivo de elecciones puede divulgar el escribano de Condado este núm. de teléfono? <input type="checkbox"/> SI <input type="checkbox"/> NO	¿Quiere Ud. trabajar en recinto electoral el día de la elección? <input type="checkbox"/> SI <input type="checkbox"/> NO						
7	Por la presente autorizo que Ud. cancele mi matrícula previa en el condado y estado a continuación.			Ciudad o División	Condado	Estado						
Favor de contestar las preguntas a continuación:				TESTIMONIO DE CALIFICACION								
8	¿Es Ud. ciudadano/a de los Estados Unidos? <input type="checkbox"/> Si <input type="checkbox"/> No ¿Habrá cumplido Ud. 18 años en o antes del día de la elección? <input type="checkbox"/> Si <input type="checkbox"/> No Si Ud. marcó "NO" en cualquiera de las preguntas más arriba no termine de rellenar este formulario. Si usted fue condenado de un delito grave y actualmente esta en libertad condicional o probation supervisada, no llene esta forma.			Yo juro/afirmo que soy ciudadano de los Estados Unidos y residente del Estado de Nuevo México; que la corte no me ha denegado el derecho de votar por motivo de incapacidad psicológica; que tengo o tendré 18 años de edad en la fecha de la próxima elección y si he sido condenado de delito grave he cumplido todas las condiciones de libertad a prueba o el gobernador me ha concedido indulto. Además, juro o afirmo que autorizo la cancelación de toda matrícula anterior con el fin de votar en el territorio de mi residencia previa; y que la información proveído esta correcto.								
FECHA: Mes Día Año ____/____/____				FIRME SU NOMBRE COMPLETO O MARQUE LA LÍNEA ABAJO _____								
9	Nombre de la persona que le ayudó a llenar este formulario:		VRA ID #		_____							
NO ESCRIBA EN LOS ESPACIOS EN COLOR GRIS - SOLO PARA USO OFICIAL												
Accepted for filing in County Registration Records					I.D.	PCT.	MUN.	PRC.DIST.	REP.DIST.	SEN.DIST.	SCHOOL	C.C.
Date _____ County Clerk _____ Filing Clerk _____												

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