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 not 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

5 NOTE: You must name a major political party to vote in primary elections. ▶▶▶ Party | If you choose NO PARTY, check this box: ❑

DAYTIME TELEPHONE NUMBER (optional)

6 May the County Clerk make this telephone number public for election purposes? ❑ YES ❑ NO

POLL WORKER

Would you like to serve as an election day precinct worker? ❑ YES

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:

8 Are you a citizen of the United States? ..... ❑ Yes ❑ No
Will you be 18 years of age on or before election day? ..... ❑ Yes ❑ 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

TODAY'S DATE
➡ Month Day Year
_____/_____/_____

ATTESTATION OF QUALIFICATION

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.

➡ 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 | Ciudad | Zona Postal

4 **¿Si Ud. va a cambier su nombre en esta solicitud, bajo que nombre completo estaba Ud. matriculado antes?** Apellido | Nombre de Pila | Otro Nombre o Inicial

PARTIDO POLITICO

5 AVISO: Ud. tiene que indicar partido político principal para votar en la elección primaria ▶▶ Partido | Si Ud. NO ELIGE Partido marque aquí ❑

NUMERO DE TELEFONO EN EL DIA (opcional)

6 ¿Con motivo de elecciones puede divulgar el escribano de Condado este núm. de teléfono? ❑ SI ❑ NO

EMPLEADO/A EN URNA ELECTORAL

¿Quiere Ud. trabajar en recinto electoral el día de la elección? ❑ SI

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:

8 ¿Es Ud. ciudadano/a de los Estados Unidos? ..... ❑ Si ❑ No
¿Habrá cumplido Ud. 18 años en o antes del dia de la elección? .. ❑ Si ❑ 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 probación supervisada, no llene esta forma.

FECHA:
➡ Mes Dia Año
_____/_____/_____

TESTIMONIO DE CALIFICACION

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. Ademas, 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 informacion proveido esta correcto.

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								

NMVR-1 HSD (2012)