



**Patient Registration Form/Family Assistance Plan Application**

Name of Head of Household		Place of Employment		
Street Address	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

**Please list spouse and dependents under age 18**

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

**Annual Household Income**

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
<b>Total Income</b>				

<b>Verification Checklist (attach copies)</b>	<b>Yes</b>	<b>No</b>
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return and three (3) most recent pay stubs		
Insurance: Insurance card (s)		
Medicaid: Application made or evidence of rejection		

**I certify that the information shown above is correct and understand verification is required for approval.**

\_\_\_\_\_  
**Name (Print)**

\_\_\_\_\_  
**Signature/Date**

<b>Office Use Only</b>	
Pay class approved: _____	Effective Date: _____
Approved by: _____	Effective Date: _____

All information on this Application is kept confidential. By signing this Application, you are stating that all information is true and accurate to the best of your knowledge. Falsifying information can lead to a reversal of this Application and charges will be filed against you in the State of New Mexico.