**RIO ARRIBA COUNTY**
**INDIGENT CLAIMS ADMINSTRATION**
INMATE APPLICATION

*CONFIDENTIAL*

NAME_______________________________________________________________________________
LAST NAME FIRST NAME MI SOCIAL SECURITY#

ADDRESS____________________________________________DOB ______________________________

_________________________________________________________________________________
CITY STATE ZIP CODE

**Hospital Name**: ____________________________________**Date of Service**: _________________

**Provider Name**: ___________________________________ **Account #**: _____________________

**Amount of Bill** __________________ **Balance Due:** ____________________________

**Co-Pay:**____________________ **Medical**_____ **Mental**_____ **Dental**_____ **Other**_____

The above named applicant is an inmate at the Rio Arriba County Detention Center.

I hereby certify that the above information, given for the purpose of obtaining assistance from the indigent fund, is true and correct and authorize you to obtain such information as you may require concerning this application.

DATED THIS_______________DAY OF________________, 2021

_________________________
*Applicant*

This is to certify that the above named indigent patient has been a resident of the Rio Arriba County Detention Center from _______________ and is expected to be here until ____________. As a resident of Rio Arriba County Detention Center, he/she does not receive any income or pay any utilities. (Please provide copy of ID with this application.)

DATED THIS_______________DAY OF________________, 2021

_________________________
Detention Administrator
or Authorized Representative

***SUBSCRIBED TO AND SWORN TO, BEFORE ME THIS______DAY OF____________, 2021***

_________________________
***NOTARY PUBLIC***

MY COMMISSION EXPIRES:_________________

_________________________ _____________
**Authorized Hospital Representative** **Date:**