FY 14-15

Non-Metro Area Agency on Aging
Cooperative Health Assistance Services (CHAS) for Ages 55+
Application for Assistance

Date:

Name: _____ Street Address:_____

Mailing Address: _____City: _____ Zip:_____

County: _____ Home and/or Cell Phone: _____ Last 4 digits of SS#: _____

Current Age: _____ DOB: _____ Attach a copy of **PROOF OF AGE**.

Total Household Size: _____ ***TOTAL*** Monthly Income: $_____ Attach **PROOF OF INCOME *for all household members***

Are you a Veteran?_____

STATEMENT OF HOUSEHOLD MEMBERS *WITHOUT* INCOME

Do you, or someone else living with you, ***not*** have income? ☐ Yes (Must complete information below.) ☐ No (Skip this section.)

☐ **Grandparent**: I am raising grandchildren who live with me who do ***not*** have income. How many? _____

List their names & ages: _____

☐ **Disability**: I (or someone else living with me) am unable to work due to a disability, and do ***not*** receive SSI or other financial benefit.

☐ **Economy**: I (or someone else living with me) am unable to work due to lay-off or unable to find a job - and do ***not*** receive Unemployment.

Please list household members without income: _____

_____

Complete this section ONLY if you are requesting that we assist you to pay a bill.

ACCOUNT INFORMATION ~ MUST ATTACH BILL, QUOTE OR INVOICE

Account #: _____ Company/Office Name:_____

Phone: _____ Company Mailing Address:_____

City: _____ State: _____ Zip Code: _____

REQUESTED ASSISTANCE

Choose only one.

- ☐ Prescription Medication
- ☐ Eye Care
- ☐ Dental Care
- ☐ Hearing Care/Aid
- ☐ Medical Office Visit
- ☐ Utility Payments
- ☐ Nutritional Provisions (Groceries)

BILL, QUOTE OR INVOICE

Attach a copy from one of the following:

- ☐ Pharmacy
- ☐ Optometrist or Optical Care Center
- ☐ Dentist or Dental Clinic
- ☐ Audiologist or Hearing Clinic/Office
- ☐ Doctor Office, Hospital, Medical Clinic
- ☐ PNM, NM Gas, Propane Company,
- ☐ City Utility (Water, Waste, Sewer)

REQUIRED DEMOGRAPHIC INFORMATION

For information purposes only. Choose all that apply.

- ☐ I receive Medicare. ☐ I receive Medicaid.
- ☐ I have Private Insurance (health, dental, or vision)
- ☐ I have Veteran's Benefits.
- ☐ I receive Retirement and/or Retirement Benefits
- ☐ I have other financial support (family, friends, etc.)

Is it difficult to: ☐ afford groceries ☐ prepare meals

☐ eat 2 or more meals/day ☐ shop for groceries

Applicant's Name: _____

Who completed this form?

☐ **Agency** or Senior Service Provider (Must complete information below.)

☐ **self** (senior applying for assistance)

Agency/Senior Service Provider: _____ Phone: _____

Name of Contact Person: _____ Email: _____

Comments/Explanations:

_____

_____

_____

_____

Only one application per person; each person must apply separately.

AFFIDAVIT of Accuracy

Falsification of documents is a fourth degree felony punishable by law in the State of New Mexico pursuant to the provisions of Section 31-18-15 NMSA 1978.

By signing below, I certify that the information and documents provided are true and correct.

_____ _____

Applicant's Signature ***Date***

*** * * For Non-Metro AAA staff use only * * ***

Received

Date: _____

Time: _____

☐ Fax ☐ Mail ☐ Email ☐ Hand Delivered

☐ Application Complete ☐ Incomplete

Application Summary

☐ Proof of Age ☐ Proof of Income ☐ Bill, Quote or Invoice

☐ No Income Statement ☐ Affidavit of Accuracy signed

Approval Status: ☐ <100% ☐ <185% ☐ DNQ

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary
Annual Update of the HHS Poverty Guidelines

The 2014 Poverty Guidelines

for the 48 Contiguous States and the District of Columbia

Persons in Household	Annual Poverty Guideline	Monthly Poverty Guideline	Annual 185 % of Poverty	Monthly 185% of Poverty
1	$11,670	$ 972.50	$21,590	$1,799
2	$15,730	$1,310.83	$29,101	$2,425
3	$19,790	$1,649.16	$36,612	$3,051
4	$23,850	$1,987.50	$44,123	$3,677
5	$27,910	$2,325.83	$51,634	$4,303
6	$31,970	$2,664.16	$59,145	$4,929
7	$36,030	$3,002.50	$66,656	$5,547
8	$40,090	$3,340.83	$74,167	$6,181

For families with more than 8 persons, add $4,060 for each additional person.

[Federal Register: January 22, 2014 (Volume 79, Number 14)]
[Notices]
[Pages 3593-3594]
From the Federal Register Online via GPO Access [wais.access.gpo.gov]

For more information, go to http://aspe.hhs.gov/poverty/12poverty.shtml#guidelines

Check List for Submitting the CHAS 2014 Application

1. Am I 55 & over?

   PROOF of AGE

   Drivers License; or

   State Issued Identification; or

   Passport; or

   Birth Certificate

2. Does my household make less then 185% of poverty (see guidelines)?

3. Provide proof of income for **ALL** household members.

   PROOF of INCOME

   Current Income Taxes

   Bank Statement

   Social Security Award Letter

   Retirement Statement

   Check Stubs

4. Provide copy of the bill, quote, or invoice that you are requesting assistance for (only for utilities or medical bill).

5. Who completed the form (is this section completed)?

6. Provide a Statement of household members without income (is this section completed)?

7. Applicants signature.