Ruidoso Hospice Foundation

APPLICATION

Please print clearly in ink. Mail the completed application with copies of the documents listed on page 2 to Ruidoso Hospice Foundation, P. O. Box 555, Ruidoso, NM 88355. Questions: call 505-235-8002.

NAME: _____ Date of Birth: _____

SSN: _____ Phone: _____

Physical Address: _____

Mailing Address: _____

Check one:
☐ Own ☐ Rent ☐ Share rent ☐ Supplied free of charge ☐ Homeless

List prior physical residence if less than 1 year at the current address: _____
_____

List all members in the home (use second page if necessary)**:**

Full Name	DOB	SSN	Relationship to Applicant

INCOME (Received in the past 12 months):

Employer: _____	Gross Amount Received: $ _____
Employer: _____	Gross Amount Received: $ _____
Unemployment: $ _____	Welfare (aka TANF): $ _____
Food Stamps: $ _____	SSA/SSI Benefits: $ _____
VA: $ _____	Pension: $ _____
Workman's Comp: $ _____	General Assistance: $ _____
Other Income not listed: $ _____	Other Income not listed: $ _____

- If you are employed this year provide current check stubs verifying type of income earned for all employment.
- Did the Applicant or Head of Household file a Federal/State Income Tax Return last year: ☐ Yes ☐ No
  ***If you were exempt from filing, provide proof.*

MEDICAL COVERAGE / INSURANCE

Does the Applicant have medical coverage? ☐ Yes ☐ No

Name of Insurance: _____ (include a copy of insurance card)

Does Applicant have: ☐ Medicare ☐ Medicaid (include copy of card(s))

Does Applicant have: ☐ Medicare Part D (include copy of Rx card)

ASSETS (Give value):

Provide proof of any investments or other properties owned by the Applicant or household unit:

Personal Home $ _____ Escrow Account $ _____

Stocks / Bonds $ _____ Investments $ _____

Checking Account $ _____ Savings Account $ _____

Do you receive other monies from a friend/relative to compensate your monthly expenses? ☐ Yes ☐ No

_____

- Have you filed an application with the Lincoln County Indigent Fund for assistance with medical bills within the past 12 months? ☐ Yes ☐ No
- If yes, may we contact the Lincoln County Indigent Fund Administrator to confirm your application and eligibility? ☐ Yes ☐ No

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REQUESTING ASSISTANCE FOR:

☐ Home Health services related to end of life care not covered by insurance, Medicare, Medicaid, etc., including medications and medical equipment ($2500 max per year)

☐ Hospice services not covered by insurance, Medicare, Medicaid, etc., including medications and medical equipment ($5000 max per year)

☐ Lifeline Systems (includes $25 set up fee, and $30 per month monitoring service)

SIGNATURE OF APPLICANT _____ **DATE** _____

To determine your eligibility, the following documentation MUST be provided along with the completed application:

☐ Copy of Medicare/Medicaid or other insurance card — Front and back of every card the applicant has.

☐ Copy of bank statements — 4 months of current bank statements.

☐ Proof of income — Pay stubs and/or copy of Social Security check, OR income tax return.

☐ Tax waiver (if applicable) — Only if you are exempt from filing income tax.

☐ Copy of the Prescription Plan Card (Medicare Part D) (if applicable) — Only if the applicant has Medicare Part D.

☐ Copy of a 3-month old utility bill — This provides proof of residency.

You will be notified if your application has been approved or denied.
Upon approval, your receipts must be mailed to:
Ruidoso Hospice Foundation, P. O. Box 555, Ruidoso, NM 88355

For office use only

COMMENTS _____

_____

Information verified by _____ Date _____

Application: ☐ Approved ☐ Denied

By _____ Date _____
Board Member

Date Applicant notified _____ By Phone _____ By Letter _____ *Form revised November 2026*