* NMBOPHB Medical Assistance Grant Application *

Policy - The New Mexico Annual Conference of 2002 voted to establish an Insurance Support Fund for clergy of our conference, for unreimbursed medical expenses which are not covered by the Conference-sponsored health plan. This fund was created to provide grants to active and retired clergy to assist with payment of unexpected health related expenses incurred by clergy or his/her dependent family member. This fund is authorized in the 2012 Discipline, ¶ 1506.11 (page 674). According to those provisions, a conference board of pensions may make special grants to clergy or former clergy of an annual conference who have served under appointment to that conference; or to their spouse, former spouses, or surviving dependent children (including adult dependent children). The amounts granted from this fund will be reported to the Annual Conference each year.

The NM Board of Pension and Health Benefits has adopted this policy with the purpose of providing grants to active and retired clergy to assist with the payment of unexpected health related expenses incurred by clergy member or his/her dependent family member, which are not covered under current health plans. Any United Methodist clergy (active or retired) from the New Mexico Annual Conference is eligible to apply for this grant award. The Board of Pensions and Health Benefits reserves the right to review all applications from active and retired clergy on a "needs basis". Only a limited number of grants are available each year.

Guidelines - The following guidelines shall be used in reviewing and approving all grant applications:

- Distressed clergy members of the New Mexico Annual Conference, spouses, surviving spouses or surviving dependent children (including adult dependent children) are eligible to apply for a grant. The term "clergy member" is interpreted to mean both active and retired conference members.
- A grant should only be requested to supplement health care insurance or the loss of income due to health-related problems after other resources have been utilized. Grants may be used to cover insurance deductibles or co-payments in catastrophic situations.
- An application must be completed by the participant or a person authorized to act on the participant's behalf, and requested information must be submitted to approve the grant.
- The grant amount is a maximum of $5,000.00 per family per year, whether active or retired. Each request will be reviewed on an individual basis.
- An applicant may apply several times during the year, but any grants awarded will not total in excess of $5,000.00 per calendar year.
- Claims for grant assistance must involve medical expense that has already been incurred by the clergyperson, for medical expenses not covered by Conference-sponsored health plan(s). The following are examples of possible unreimbursed medical expenses:
    - Medical insurance deductibles
    - Out-of-pocket expenses
    - Dental expenses
    - Travel expenses (including accommodations) for necessary medical care
    - Vision
    - Alternative medicine expenses
    - Hearing aides
    - Prescription costs
    - Necessary medical supplies

Process and Procedures - The New Mexico CBO and three current New Mexico Board of Pensions and Health Benefits board members appointed by the Board chair shall constitute the Grant Review Committee. The Grant Review Committee shall meet either in person or by teleconference to review and approve or reject all medical expense grant requests that have been designated as "qualified and approved for review" by the Conference Benefits Officer (CBO). (See "Attachment A, Qualified for Review").

Please complete the enclosed items and include all necessary documentation:

- Grant Application (Form A)
- Financial Information (Form B)
- Release of Information (Form C)

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Date:

Name:

Email:

Telephone:

What events have prompted your need for assistance:

Please provide a brief summary of how you will use the grant funds (attach additional info as needed):

Amount Requested (please provide copies of receipts):

Check Payable To:

Mailing Address:

Signature: _____

By submitting this form, I attest and agree to the following: To the best of my knowledge and belief, my statements in this request for financial assistance are complete and true, and I have been unable to obtain financial assistance from other sources.

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Date:	
Name:	

MONTHLY HOUSEHOLD INCOME AND EXPENSES

Income: Money you receive such as your pension or other income net of taxes (dividends, Social Security, etc.)

Fixed Expenses: Expenses that basically stay the same month to month such as mortgage payments, homeowner's insurance, car payments and insurance, etc.

Medical Expenses: Expenses that are paid on a monthly basis for medical or dental needs.

Other Expenses: Money spent to purchase goods or services that vary month to month such as food, utilities, clothing, transportation costs, etc.

MONTHLY HOUSEHOLD INCOME *(Please include income from all sources, net of taxes)*	
TOTAL MONTHLY INCOME:	

MONTHLY HOUSEHOLD EXPENSES *(Please include an estimate of all expenses)*	
Fixed Expenses	
Medical Expenses	
Other Expenses	
TOTAL MONTHLY EXPENSES:	

Attach copies of receipts, invoices, and/or statements related to the specific request for assistance. Also attach any additional information necessary to substantiate financial claims.

Signature: _____

By submitting this form, I attest and agree to the following: To the best of my knowledge and belief, my statements in this request for financial assistance are complete and true, and I have been unable to obtain financial assistance from other sources.

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Date:	
Name:	
Email:	
Telephone:	
Address:	

The undersigned, in consideration of participating in the grants and support funds administered by The Board of Pension and Health Benefits (Board) of the New Mexico Annual Conference, does hereby acknowledge that in order for the Board to administer this program in a responsible and reasonable manner, it must receive from person requesting participation in the program some certain information to verify the expenses being submitted for reimbursement. Some or all of such information may be subject to applicable federal and state law related to the protection of privacy of your health information. Specifically, you may be allowed to limit the disclosure of such information and/or place certain restrictions on the Board's use or disclosure of your health information. By signing this form, you are consenting to the Board's use and disclosure of your protected health information to enable the Board to administer this program for your benefit. You have the right to revoke this Consent at any time by giving the Board written notice of your revocation. Please understand that revocation of this Consent will not affect any action the Board took in reliance on this Consent before we received your revocation and that the Board may decline to allow you to participate in this program if you fail to sign this Consent or if you revoke this Consent.

I, _____, understand that, by signing this Consent form, I am giving my consent to the Board's use and disclosure of my protected health information to allow me to participate in the support funds of the Board of Pension and Health Benefits.

Signature: _____

You are entitled to a copy of this consent after you sign it.

Please send completed forms to:
NM Conference Benefits Officer
11816 Lomas Blvd NE
Albuquerque, NM 87112