* NMBOPHB Medical Assistance Grant Application *

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.

* NMBOPHB Medical Assistance Grant Application *

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.

* NMBOPHB Medical Assistance Grant Application *

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