Fort Bayard Medical Center
41 Fort Bayard Road
Santa Clara, NM. 88026

Financial Disclosure Statement

Name: _____ Social Security: _____

Spouse's Name (if applicable): _____ Social Security: _____

Do you own or have interest in property other than the property which is the primary residence of spouse or dependent children? _____ Yes _____ No

Monthly Income (Pensions, Rental Income, Annuities, Social Security, Interest Income, etc.):

Source	Applicant	Spouse
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

If there is a retirement pension please list name of Group as well as their address and phone number:

_____

_____

_____

_____

Bank Accounts (CD's, Stocks and Bonds)

Bank Name, Address & Zip Code	Type of Account	Account Balance
		$
		$
		$
		$
		$

Certification

The Department of Health and Fort Bayard Medical Center are authorized to investigate the financial information provided by applicants or their representative(s) to determine their ability to pay for services. Any applicant or representative(s) who knowingly withholds or falsifies financial information shall be liable for all expenses incurred for legal action related to the recovery of valid indebtedness to the State of New Mexico.

I hereby certify that the foregoing information is true and correct to the best of my knowledge and belief. I agree to report any change in income to the Financial Specialist of Fort Bayard Medical Center.

_____

Name of Person Completing Information (Please Print)

_____ _____

Signature of Person Completing Information Date

_____

Relation to Applicant if other than Applicant