



SCI Program Application

Si Ud. necesita este formulario en español, llame al Departamento 1-888-997-2583. Intérpretes están disponibles gratuitamente.

The information provided in this application may be used to determine eligibility for other Medicaid programs.

Programs of Medical Assistance

State Coverage Insurance (SCI) Applying through an Employer Applying as an Individual

To qualify for SCI, you must meet certain guidelines, such as:

- An individual or employee 19 through 64 years old
- No current health insurance coverage
- Household income meets program guidelines
- Not eligible for certain government health insurance programs (Medicare, Medicaid, CHAMPUS, etc.)

Choose Additional Medical Assistance Program(s) You Want to Apply For: Families or Children Only Women's Family Planning Pregnant Women Lost SSI Working Disabled

Please Send Me Information on Additional Assistance Programs (Such as Food Stamps, Cash Assistance or Paying for Home Heating or Cooling): YES NO

Applications and Proof Can Be Mailed to One of These Offices

If you live in Bernalillo, Sandoval, Santa Fe, Torrance or Valencia Counties –

Northern SCI Unit, Income Support Division
830 Camino Del Pueblo, Bernalillo, NM 87004
1-866-773-9939

If you live in any other New Mexico County –

Southern SCI Unit, Income Support Division
655 Utah Avenue
Las Cruces, NM 88001
1-866-765-4148

If you would like more information on the State Coverage Insurance (SCI) program, please visit the website at: www.insurenwmxico.net or 1-888-997-2583

Remember to provide proof of the following with your application: ▼

One or more of the following may be used as proof... ▼

<input type="checkbox"/> Identity	Copy of driver's license, Government ID with photo, INS letter or immigration card (<i>must be verified by an agent of the state, see pg. 6 of application for more information</i>)
<input type="checkbox"/> U.S. Citizenship	Copy of U.S. passport, Certificate of Naturalization, Certificate of Citizenship, U. S. Birth certificate, certification of birth issued by the Department of State (<i>must be verified by an agent of the state, see pg. 6 of application for more information</i>) Do not send your Social Security Card.
<input type="checkbox"/> Legal Immigrant Status	Copies of Immigration card, or INS or Department of Homeland Security letter
<input type="checkbox"/> Income (for you and your spouse)	Current check stubs or copies of paychecks for the past 30 days or a Letter from your employer A copy of your check or award letter from Social Security, Veteran's, retirement, or other sources Self-employment records such as Income Tax forms or Personal Wage Records
<input type="checkbox"/> Health Insurance	Copies of ID card or letter from your health insurance company
<input type="checkbox"/> Pregnancy Due Date (if it applies to you)	Medical statement of due date
<input type="checkbox"/> Dependent Childcare Expenses (if it applies to you)	Copy of receipts, statement from provider, or proof of payment such as money orders or cancelled checks

Provide ONLY if you are applying for Medical Assistance for Disabled Adults or You Have Lost SSI ▼

Value of Things You Own Copies of current statements



If you need more information:
Call 1-800-432-6217 or visit the Human Services Department's website at:
<http://www.state.nm.us/hsd/isd.html>



FOR INTERVIEWER OR ISD USE ONLY

Status <input type="checkbox"/> Application <input type="checkbox"/> Redetermination	Former Recipient <input type="checkbox"/> Yes <input type="checkbox"/> No	Cat.	Application Date	Date Mailed	Date Received
ISD Worker Number		Non-ISD Interviewer's Name		Non-ISD Interviewer's Location	



If you are a person with a disability and you require this information in an alternative format, or require a special accommodation to participate in any public hearing, program or services, please contact the NM Human Services Department toll-free at 1-800-432-6217 or through the New Mexico Relay System TDD at 1-800-659-8331 or by dialing 711. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (08/22/08)

1. Name and Contact Information

Your Name	Email Address			Telephone Contact # ()
Home Address – Physical Address	City	County	State	Zip Code
Mailing Address if Different from home address <input type="checkbox"/> Same	City	County	State	Zip Code

2. You and People Who Live with You

Please tell us about yourself and all of your household members.
You only have to provide Social Security Numbers and Citizenship information for those who are applying for Medical Assistance.

Name (First and Last)	Relationship	Social Security # (if you have one)	Sex M/F	Date of Birth	Race & Ethnicity	Citizenship U.S Citizen or Immigrant	Legal Immigrant
1.	(Self)					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.						<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Are you applying for SCI Medical Assistance for the above named spouse or parent of your child(ren)? YES NO

Were any of the above born in New Mexico? YES NO

If yes, please complete section on page 6 and return it with your application.

3. State Coverage Insurance (SCI)

Were you offered SCI Health Insurance by your employer? Yes No

Did you refuse SCI Health Insurance? Yes No

If yes, what was the date that you refused SCI Health Insurance? _____

ENROLLMENT AS AN INDIVIDUAL -- (Do not complete this section if you are applying through an Employer)

Are you self-employed Yes No

If you are not self-employed, are you currently employed? Yes No

ENROLLMENT THROUGH AN EMPLOYER -- (Do not complete this section if you are applying as an Individual)

Please list the name and address of the business: _____

If your employer is using an insurance broker, please list the name: _____

All applicants (individuals and employer groups) must choose an SCI Managed Care Organization (MCO).

What managed care organization (MCO) is being selected? (Check only one):

Lovelace (SCI Plan)

Molina Healthcare (SCI Plan)

Presbyterian Healthcare (SCI Plan)

You will remain with the health plan that you select for 12 months. Please be certain of your selection

4. Income

Gross income is counted to determine your eligibility. Gross income means a household's total, countable income, before any deductions have been made. **You must send proof of all earned income received for the last 30 days for all people in your household.**

(a) Checkmark any income you may have including benefits for you and all people living with you:

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Employment | <input type="checkbox"/> Self Employment | <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Cash Assistance | <input type="checkbox"/> Child Support | <input type="checkbox"/> Social Security | <input type="checkbox"/> Retirement |
| <input type="checkbox"/> Veterans | <input type="checkbox"/> Military | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

(b) List all the income information for you and each person living with you:

Person with Income	Income from?	Monthly Amount Before Taxes	How Often Received? Daily, Weekly, Biweekly, Monthly, Semi Monthly
		\$	
		\$	
		\$	

5. Medical Health Insurance Coverage

By accepting medical assistance, you assign (give) HSD all rights to medical support and to payment for medical care from a third party. A third party can include an insurance company or another person who must pay for your medical care and services. You must help HSD find out about any third parties who may have to pay for your medical care. If you don't help HSD find out about these third parties, you may not be approved or you may lose your medical assistance, unless you show a good reason for not helping HSD.

(a) Have you or anyone that lives with you recently dropped health insurance in the last 6 months? Yes No

What date was insurance dropped: _____

Explain why insurance was dropped: _____

(b) List all private health insurance and Medicare and Medicaid information for you and all people living with you:

Persons Covered	Insurance Company Name	Member ID #	Start Date	End Date

6. Parents Not Living With Their Children

By accepting medical assistance for your children, you assign (give) HSD rights to collect child support from an absent parent. Please list all the information for your children's parent(s) that are not living with you:

Child Name	Absent Parent Name

7. Expenses

How much do you pay monthly for Dependent / Childcare? ► \$

Do you have any unpaid bills for medical services received in the last 3 months? Yes No

If Yes, name of child and which Months: _____

8. Things You Own Complete this section ONLY if you applying for medical assistance for DISABLED adults.

(a) Cash on hand, checking account, savings account, CD – Certificate of Deposit, Royalties, Life or Burial Insurance, Trust, Retirement Account.

(b) Describe all of the items above that are owned by you and all the people living with you:

Items	Who Owns them?	\$ Value	Where?
		\$	
		\$	
		\$	

9. Register to Vote

If YOU are NOT registered to vote where you live now, **Would you like to register to vote here today?** (Please check one) Yes No
IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

The NATIONAL VOTER REGISTRATION ACT provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

IMPORTANT: Applying to register or declining to register to vote WILL NOT AFFECT the amount of assistance that you will be provided by this agency.

Signature	Date
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CONFIDENTIALITY: Whether you decide to register to vote or not, your decision will remain confidential. IF YOU BELIEVE THAT SOMEONE HAS INTERFERED with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Office of the Secretary of State, 419 State Capital, Santa Fe, NM, 87503, (phone: 1-800-477-3632).

10. Applicant Information

PRIVACY INFORMATION - The information you give HSD will be used to determine whether your household is eligible or continues to be eligible to take part in the HSD programs. We will check this information through computer matching programs. This information will also be used to make sure that you meet program rules and help us to manage the program. This information may be given to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of picking up persons fleeing to avoid the law. If you get benefits that you were not eligible for and have to pay them back, this is called a claim. If your household gets a claim against your household, the information on this application, including all Social Security Numbers, may be given to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including social security numbers of each household member is voluntary. However, each person applying for assistance must give a social security number or it will result in denial of program benefits to each individual applicant failing to give a social security number. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information or social security numbers. Any Social Security Numbers provided will be used and disclosed in the same manner as Social Security Numbers of eligible household members. We will also check with other agencies, the Federal Income and Verification Service (IEVS), and the public assistance reporting information system (PARIS) about the information that you give us. This information may affect your household eligibility and benefit amount. (10/23/2009)

RESPONSIBILITY TO REPORT CHANGES – The information I give during the application process is used to determine eligibility. Changes in income or family size do not need to be reported until recertification, per SCI regulation section 12 of 8.262.400 NMAC, which applies only to the SCI program. I understand that I need to report if I move out of state or get other health care coverage within ten (10) days of the date of the change or as otherwise required.

CONFIDENTIALITY – All information I give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which I have applied. Confidential information may also be released to other federal and state agencies. All information will be used to determine eligibility and/or to provide services. (03/29/2012)

RELEASE OF MEDICAL INFORMATION – By signing this application, I allow HSD to examine medical records needed for eligibility decisions and/or for payment of benefits.

FAIR HEARINGS - If you don't agree with a decision we make about your case, you can ask for a Fair Hearing in person, by telephone 1-800-432-6217 or at (505) 476-6213 or in writing within 90 days of the date that a notice has been sent informing you of any action that has been taken on your case. Please mail your request to the HSD Hearing's Bureau at PO Box 2348 Santa Fe, NM 87504. (04/10/2012)

CIVIL RIGHTS STATEMENT – All programs administered by the Human Services Department (HSD) are equal opportunity programs. If you believe you have been treated unfairly because of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public assistance program, you may file a complaint. Complaints of discrimination may be filed with the New Mexico Human Services Department central office, ATTN: Quality Improvement Section, Pollon Plaza, P.O. Box 2348, Santa Fe, New Mexico 87504-2348 or the local Human Services county office. Complaints of discrimination about the Supplemental Nutrition Assistance Program may be filed with the USDA, Director, Office of Adjudication, 1400 Independence Ave, S.W. Washington, DC 20250-9410 or call 1-866-632-9992 or 202-401-0216 (TDD). Complaints of discrimination about Cash Assistance and Medical Assistance programs may be filed with the Office of Civil Rights, Department of Health & Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202 or call 1-800-368-1019 (voice) and 1-214-767-8940 (TDD). (08/16/11)

If you have an application pending with the Social Security Administration or a pending Medicaid application, it is possible that you may be eligible retroactively (i.e., for months that are in the past) for full-coverage or no-cost Medicaid. SCI may require premiums and co-payments, which will **not** be refunded to you for the months in which you are later found to be retroactively eligible for full-coverage or no-cost Medicaid or Medicare.

BY SIGNING THIS APPLICATION, I AGREE TO THE FOLLOWING:

- If any of the contact information provided on this application changes, I will inform HSD immediately.
- I am declaring the identity of my children under age 16.
- To provide all information and proof needed to determine eligibility.
- To permit the Human Services Department (HSD) to contact persons or agencies to verify needed information if I am not able to provide the information.
- To allow all information I give to HSD to be matched by computer with other federal, state, and local agencies.
- SCI benefits are similar to a basic commercial health insurance plan. Premiums and co-payments may be required. If required, monthly premium payments must be paid on time. By submitting this application, I acknowledge that SCI premiums and co-payments, if applicable, are not refundable and I voluntarily forfeit all payments that I may have made. Native Americans enrolled in the program do not have co-payments.
- I acknowledge the limited nature of SCI and understand that if I am hospitalized at the time of initial approval for SCI, I may enroll with the Managed Care Organization (MCO) but the MCO shall not be responsible for my health care costs until after discharge from the hospital.
- HSD will use the information I give to determine my eligibility, so the information must be as correct as possible. If the information I report is false, incorrect, or incomplete, my benefits may be denied or closed.
- If I knowingly give false, incorrect or incomplete information, I may be prosecuted for that crime.
- I understand that I must pay back any benefits that I am not eligible to receive.

11. Your Signature (Your authorized representative may also sign here)

► **Sign Here** X _____ **Today's Date** _____

Managed Care Organization (MCO) FACT SHEET State Coverage Insurance

Lovelace SCI



A. Payment Methodology

Premiums must be pre-paid for each month of coverage. The first payment is due by check or money order when the member enrolls. Subsequent payments are by check or money order only.

B. Providers

Lovelace uses providers who have contracted for the SCI plan. To determine if your provider is contracted you can go online to <http://www.lovelacehealthplan.com/directory.php> or you can also call to check if a provider is in the SCI network by calling 1-800-808-7363.

C. Drug Formulary

The drug formulary is a list of approved drugs. You may need to obtain an authorization for your prescription. To check if your prescription is covered you can call 1-800-808-7363 or visit online at <http://www.lovelacehealthplan.com/pdf/LHP%20TWO-TIER%20FORMULARY.pdf>

For questions regarding enrollment in the Lovelace SCI, please call (505) 727-5670 or (888) 665-5401 or visit the website at www.lovelacehealthplan.com.

Molina Healthcare



A. Payment Methodology

The first payment is due by check or money order when the member enrolls. Subsequent payments are by check or money order only. Premiums must be pre-paid and received by Molina by the 20th of each month, to ensure coverage for the following month. Direct bank draft can be arranged, if requested.

B. Providers

Molina Healthcare uses providers who have contracted for the SCI plan. To determine if your provider is contracted, you can go online at <http://www.molinahealthcare.com>. You may also call the Customer Service department at 1-866-403-3018 to check to see if a provider is in the SCI network.

C. Drug Formulary

The drug formulary is a list of approved drugs. You may need to obtain a prior authorization for your prescription. To check to see if your prescription is covered please call 1-866-403-3018.

For questions regarding the Molina SCI plan please call the Molina Customer Service Department at 1-866-403-3018, outside of Albuquerque, or 348-1578 in Albuquerque. You may also access the website at <http://www.molinahealthcare.com>.

Presbyterian Health Plan



A. Payment Methodology

Premiums must be pre-paid for each month of coverage. The first payment is debit or credit only. Subsequent payments can be debit, credit, or automatic withdraw from a checking or savings account.

B. Providers

Presbyterian uses providers who have contracted for the SCI plan. To determine if your provider is contracted you can go online to <http://www.phs.org/directory/index.shtml>. You can also call to check if a provider is in the SCI network by calling 1-866-593-7434.

C. Drug Formulary

The drug formulary is a list of approved drugs. Your prescription may not be on the list. You may need to get an authorization for your prescription. To check if your prescription is covered you can call 1-866-593-7434 or visit the website at <http://www.phs.org/facilities/pharmacy/formulary.html>.

For questions regarding the Presbyterian SCI plan please call Presbyterian at 923-8200 or 1-866-606-7737. You may also access the website at <http://www.phs.org/>.

Fact Sheet on Citizenship Requirements for State Coverage Insurance (SCI)

Federal regulations now require that all individuals receiving State Coverage Insurance (SCI) provide specific ORIGINAL (not copies) documents that verify Citizenship or Legal Permanent Status and Identity.

IMPORTANT:

Original documents must be viewed and copied. Call the SCI units at 1-866-765-4148 or 1-866-773-9939 to find the closest office to verify your documentation. This is a one time process.

Proof of Citizenship and Identity – These are some examples of acceptable documents that show U.S. Citizenship and Identity. Applicants will need to provide an original of one of the following:

- A Passport
- A Certificate of Naturalization (INS Form 550 or N-570)
- A Certificate of U.S. Citizenship (INS Form N-560 or N-561)

If you do not have one of the above documents, you will need to provide separate documents for citizenship and identity.

- **Proof of Citizenship only** - A U. S. birth certificate is the easiest way to establish proof of citizenship.
 - **If you were born in New Mexico and do not have a copy of your birth certificate, please attach this sheet to your application with the information requested below.** You may also call the SCI unit office in either Las Cruces (1-866-765-4148) or Bernalillo (1-866-773-9939) with this information. Every effort will be made by the SCI unit to verify your birth certificate through the New Mexico Department of Health.

Please provide all of the following information for all members of your household who are applying for assistance *and* send this page with your application.

Name at birth ▼	Date of Birth ▼	County of birth (in New Mexico) ▼	Gender (Male or Female) ▼	Mother's First Name ▼	Mother's Maiden Name ▼

- If you were NOT born in New Mexico or if the SCI unit employee is not able to verify your birth certificate, you will need to provide an original U. S. birth certificate for verification.
- **Legal Permanent Residents** - original documentation from INS showing immigrant status and date of legal entry (I-94) into the USA.

- **Proof of Identity Only** – These are some examples of acceptable identification:
 - Driver's License
 - Native American Tribal Document
 - Other Government Identification card (with picture, name and date of birth)

Questions?

If you have questions about SCI, need further information about verifying your citizenship and identity or want to discuss other ways to verify your documentation, you may also call the *Insure New Mexico!* Solutions Center at 1-888-997-2583.

PERSONAL INFORMATION					This information <u>not</u> to be copied.	
1	NAME Last	First	Middle Name or Initial	Gender	Birth Date	Social Security Number
PHYSICAL STREET ADDRESS WHERE YOU LIVE NOW						
2	Street Address		Apartment, Unit, or Lot #	City	Zip	
ADDRESS WHERE YOU GET YOUR MAIL (If different from above)						
3	Address			City	Zip	
4	If you are changing your name on this application, under what full name were you previously registered?			Last Name - First Name - Middle Name or Initial		
POLITICAL PARTY		DAYTIME TELEPHONE NUMBER (optional)		POLL WORKER		
5	NOTE: You must name a major political party to vote in primary elections. ▶▶▶	Party	If you choose NO PARTY, check this box: <input type="checkbox"/>	6	May the County Clerk make this telephone number public for election purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO	Would you like to serve as an election day precinct worker? <input type="checkbox"/> YES
7	I hereby authorize you to cancel my previous registration in the following county and state.		City or Township	County	State	
Please answer the following questions:				ATTESTATION OF QUALIFICATION		
8	Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No Will you be 18 years of age on or before election day? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked "NO" to any of the questions above, do not complete this form. If you have been convicted of a felony and are currently on parole or supervised probation do not complete this form			I swear/affirm that I am a citizen of the United States and a resident of the state of New Mexico; that I have not been denied the right to vote by a court of law by reason of mental incapacity; that I am, or will be at the time of the next election, 18 years of age; and, if I have been convicted of a felony, I have completed all conditions of parole and supervised probation, served the entirety of a sentence or have been granted a pardon by the governor. I further swear/affirm that I am authorizing cancellation of any prior registration to vote in the jurisdiction of my prior residence; and that all the information I have provided is correct.		
TODAY'S DATE ➡ Month Day Year ____/____/____				➡ SIGN YOUR FULL NAME OR MARK ON THE LINE BELOW: [_____]		
9	Name of agent who assisted you in filling out this form:		VRA ID #			
DO NOT WRITE IN SHADED AREAS - FOR OFFICIAL USE ONLY						
Accepted for filing in County Registration Records					I.D.	PCT.
Date _____/_____/_____ County Clerk _____ Filing Clerk _____					MUN.	PRC.DIST.
					REP.DIST.	SEN.DIST.
					SCHOOL	C.C.

NMVR-1 HSD (2012)

INFORMACION PERSONAL					Esta información no se debe copiar.	
1	NOMBRE: Apellido	Su Nombre de Pila	Otro Nombre o Inicial	Género	Fecha de Nacimiento	Número de Seguro Social
DIRECCION DONDE UD. VIVE AHORA						
2	Número y Nombre de la Calle		Departamento, Unidad o # de Lote	Ciudad	Zona Postal	
DIRECCION DONDE UD. RECIBE SU CORRESPONDENCIA						
3	Dirección			Ciudad	Zona Postal	
4	¿Si Ud. va a cambiar su nombre en esta solicitud, bajo que nombre completo estaba Ud. matriculado antes?			Apellido	Nombre de Pila	Otro Nombre o Inicial
PARTIDO POLITICO		NUMERO DE TELEFONO EN EL DIA (opcional)		EMPLEADO/A EN URNA ELECTORAL		
5	AVISO: Ud. tiene que indicar partido politico principal para votar en la elección primaria ▶▶	Partido	Si Ud. NO ELIGE Partido marque aquí <input type="checkbox"/>	6	¿Con motivo de elecciones puede divulgar el escribano de Condado este núm. de teléfono? <input type="checkbox"/> SI <input type="checkbox"/> NO	¿Quiere Ud. trabajar en recinto electoral el día de la elección? <input type="checkbox"/> SI
7	Por la presente autorizo que Ud. cancele mi matrícula previa en el condado y estado a continuación.		Ciudad o División	Condado	Estado	
Favor de contestar las preguntas a continuación:				TESTIMONIO DE CALIFICACION		
8	¿Es Ud. ciudadano/a de los Estados Unidos? <input type="checkbox"/> Si <input type="checkbox"/> No ¿Habrá cumplido Ud. 18 años en o antes del día de la elección? <input type="checkbox"/> Si <input type="checkbox"/> No Si Ud. marcó "NO" en cualquiera de las preguntas más arriba no termine de rellenar este formulario. Si usted fue condenado de un delito grave y actualmente esta en libertad condicional o probación supervisada, no llene esta forma.			Yo juro/afirmo que soy ciudadano de los Estados Unidos y residente del Estado de Nuevo México; que la corte no me ha denegado el derecho de votar por motivo de incapacidad psicológica; que tengo o tendré 18 años de edad en la fecha de la próxima elección y si he sido condenado de delito grave he cumplido todas las condiciones de libertad a prueba o el gobernador me ha concedido indulto. Además, juro o afirmo que autorizo la cancelación de toda matrícula anterior con el fin de votar en el territorio de mi residencia previa, y que la información proveído esta correcto.		
FECHA: ➡ Mes Día Año ____/____/____				FIRME SU NOMBRE COMPLETO O MARQUE LA LÍNEA ABAJO [_____]		
9	Nombre de la persona que le ayudó a llenar este formulario:		VRA ID #			
NO ESCRIBA EN LOS ESPACIOS EN COLOR GRIS - SOLO PARA USO OFICIAL						
Accepted for filing in County Registration Records					I.D.	PCT.
Date _____/_____/_____ County Clerk _____ Filing Clerk _____					MUN.	PRC.DIST.
					REP.DIST.	SEN.DIST.
					SCHOOL	C.C.

NMVR-1 HSD (2012)