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LOS ALAMOS
where discoveries are made

HEALTH CARE ASSISTANCE PROGRAM (HCAP) POLICY

SECTION I. PURPOSE AND ADMINISTRATION.

A. PURPOSE.

1. This Health Care Assistance Program Policy (this "HCAP Policy") is established pursuant to the Indigent Hospital and County Health Care Act, Section 27-5-1 through 27-5-18, N.M.S.A. 1978 (the "Act"). The general purpose of this HCAP Policy is to establish rules and regulations for the administration of the Los Alamos County Health Care Assistance Fund ("HCA Fund"). The HCA Fund consists of gross receipts tax revenues and was established by County ordinance for the purpose of disbursing financial payment to eligible HCAP Providers for health care and treatment of indigent County Patients as determined eligible by the regulations and provisions of this HCAP Policy.

2. The HCA Fund exists to assist eligible indigent Patients who are residents of Los Alamos County with payment of their health care expenses. The Fund is not intended to serve as health care insurance or a substitution for healthcare insurance, but is intended to be a payer of last resort.

B. ADMINISTRATION OF HCA FUND. The HCA Fund shall be administered by the County Health Care Assistance Board (the "Board"), formerly the County Indigent Hospital and Health Care Board, which shall be composed of the members of the County Council of the Incorporated County of Los Alamos and the Chair and Vice-Chair of the County Council shall be the Chair and Vice-Chair, respectively, of the Board. The Board shall have and exercise all powers and duties enumerated in the Act at Section 27-5-6, N.M.S.A. 1978.

C. HCA ADMINISTRATOR. The County Manager shall designate and supervise an HCA Administrator to manage and administer the provisions and procedures of the HCAP Policy. The Board hereby delegates its power and authority under the Act, as and to the extent authorized by the Act, to the HCA Administrator. The HCA Administrator may utilize the facilities and the resources of all County Departments and seek the assistance of the New Mexico Human Services Department, as provided in Section 27-5-16, N.M.S.A. 1978. The HCA Administrator may further delegate specific tasks to other County staff, or to a contractor.

D. INTERPRETATION. This Policy shall be interpreted and construed to conform to the Act. It shall be HCAP Policy that all persons who possess or are eligible for alternative means to cover their own health care expenses shall do so. Patients must demonstrate an inability to provide for their own healthcare expenses as determined by the HCA Administrator in conformity with this Policy. The provisions of this HCAP Policy are intended to accomplish this objective and, therefore, the provisions shall be interpreted strictly. The HCA Administrator shall assure that every reasonable effort has been made to demonstrate that the person applying for such assistance is eligible. Interpretations of the provisions of this

HCAP Policy shall be made by the HCA Administrator, subject to review by the County Manager and County Attorney.

E. SUPPLEMENTS. Supplements to this HCAP Policy that are consistent with the provisions of the Act may be written by the HCA Administrator and included as a part of the HCAP Policy upon review and approval of the County Manager and County Attorney. Written supplements are not a revision or amendment to the HCAP Policy, but are written to provide interpretation or clarification of provisions, to provide illustration, examples, forms, other additional information or detail procedures deemed appropriate or necessary to administer the HCAP Policy.

F. REVISIONS. Amendments or revisions to the HCAP Policy will be effective only if adopted by the Board.

G. EFFECTIVE DATE. This HCAP Policy is adopted this 29th day of November, 2016, and is effective for all purposes December 1, 2016. This HCAP Policy supersedes and replaces in its entirety the Los Alamos Indigent Health Care Policy approved by the Board on June 27, 2014 and effective July 1, 2014.

H. SEVERABILITY. If any section, subsection, clause, phrase or portion or this HCAP Policy is, for any reason, held invalid or unconstitutional by any government agency or court of competent jurisdiction, such portion shall be deemed a separate, distinct and independent provision and such holding shall not affect the validity of the remaining portions hereof.

SECTION II. PATIENT ELIGIBILITY.

A. A Patient shall be eligible to receive benefits under this HCAP Policy **only** if:

1. **RESIDENCY.** The Patient has been a resident of Los Alamos County continuously and without interruption for a period of ninety (90) days prior to the date of service.

2. **INCOME.** The Patient's household annual gross income, less any adjustments permitted under this HCAP Policy, equals or is less than 225% of federal poverty guidelines. An eligible income level as established by this HCAP Policy, including asset limitations, conclusively establishes that a Patient after consideration of that income and those assets, is not able to pay the cost of medical care, as well as other necessities of life for himself and his dependents; and

3. **ASSETS.** The Patient's family shall have no more than Ten Thousand Dollars ($10,000) in assets or no more than Five Thousand Dollars ($5,000) in assets if Patient is a single person.

4. **JAIL DETAINEE.** For purposes of eligibility under this HCAP Policy, any person detained in the Los Alamos County jail is deemed to otherwise meet the eligibility requirements while incarcerated.

B. PAYMENT LIMITATIONS.

1. Payment for all services is limited to fifty thousand dollars ($50,000) lifetime per person. This amount shall be calculated and include all claims for services rendered and paid out of the IHC Funds. A Patient whose benefits have reached the specified amount is no longer an eligible Patient.

2. Payment for all claims eligible for payment shall not exceed fifteen thousand dollars ($15,000) per person, per County fiscal year.

C. REQUIRED NOTIFICATION. A Patient is required to immediately notify the HCA Administrator in writing if there has been any change in the Patients' circumstances that has caused or may cause the Patient to be ineligible to receive benefits under this HCAP Policy.

SECTION III. APPLICATIONS GENERALLY.

A. COMPLIANCE. The HCA Administrator shall accept and consider for HCA Fund assistance only those applications for which the Patient has complied with the provisions of this HCAP Policy.

B. PATIENT COOPERATION. Failure of a Patient to cooperate in the investigation of information, or in providing the HCA Administrator with authorization to obtain information, is grounds for rejecting the application.

C. SUBMITTAL. An application for HCAP assistance may be submitted at any time to the Provider. The Patient, the Patient's spouse, the Patient's parents or guardian if the Patient is a minor, or the guarantor of the Patient's expenses may submit the application. A minor may initiate an application on his or her own behalf if emancipated. An application made on behalf of a deceased person will not be accepted.

D. APPLICATION VERIFICATION. The Patient shall then provide a completed HCAP Application for Assistance to the Social Services Division of Los Alamos County, who will process the Application on behalf of the HCA Administrator. Social Services Division, on behalf of the HCA Administrator, shall review the application and take additional reasonable steps to verify that the information submitted is true and correct within a reasonable time after submittal of the application. Social Services Division may, on behalf of the HCA Administrator, require the Patient to provide information including, but not limited to, verification from the Human Services Department or New Mexico Health Insurance Exchange indicating ineligibility for assistance and/or affordable health insurance, adult household members' financial contribution affidavits, or other information. Social Services Division may, on behalf of the HCA Administrator, require the Patient to participate in an oral interview to determine eligibility.

E. INCOMPLETE APPLICATIONS. Social Services Division, on behalf of the HCA Administrator, will notify the Patient within a reasonable time if the application is incomplete. The Patient will have thirty (30) days after the notification date to provide further supporting documentation. If requested information is not received within the allotted time, the application file will be closed.

SECTION IV. APPLICATION CONTENTS.

Applications shall include the following:

A. PATIENT IDENTIFICATION. The HCAP Application for Assistance shall include, but not be limited to, the following: Name, address, or other personal identification of the Patient deemed appropriate by Social Services Division, on behalf of the HCA Administrator. If the Application is submitted on behalf of the Patient, it shall additionally include: Name of agency, provider, or Patient's representative submitting the application; along with specific authorization in

writing, signed by the Patient or the Patient's agent if the Patient is unable to sign, that the Patient's representative is authorized to submit the application on the Patient's behalf.

B. RESIDENCY. For purposes of determining residency, the HCA Administrator may consider any evidence of residing in a permanent or principal living quarters or residence within the County, such as utility bills, lease agreements, voter registration or other documentation, as Social Services Division may find necessary and sufficient, on behalf of the HCA Administrator. If only one parent of a minor child of separated or divorced parents resides in Los Alamos County, the Patient, on behalf of the minor child, must provide any Separation or Divorce Decree pertaining to the custody of the minor child. HCA Funds may only be used to pay the cost of eligible costs for a minor child whose custodial parent resides in Los Alamos County and only if the child and the custodial parent qualify to receive the benefit of HCA Funds.

C. JAIL DETAINEE. For purposes of eligibility under this HCAP Policy, any person detained in the Los Alamos County jail is deemed to meet the Patient eligibility requirements while incarcerated. An HCAP Application is not required; however, verification of incarceration shall be provided by the law enforcement agency to Social Services Division, on behalf of the HCA Administrator, in a timely manner.

D. INCOME AND ASSETS. The Patient must provide proof of income and assets as required by this HCAP Policy and as may be deemed necessary and sufficient by the Social Services Division, on behalf of the HCA Administrator, to verify eligibility. Except for allowed assets described in Section IV. D.4. below, an applicant must also demonstrate that any other available sources of payment assistance have been exhausted or are otherwise unavailable or insufficient.

1. HOUSEHOLD ANNUAL GROSS INCOME DETERMINATION.

(a) The Patient is required to provide current pay stubs or documentation of other earned and non-earned income, including most recent state and federal income tax returns, and any other documentation necessary to determine the Patient's household annual gross income. Household annual gross income shall include all income earned or received, including without limitation amounts that are untaxed or with respect to which taxes are deferred. Child support received by the Patient shall not be included in calculating the Patient's annual gross income. Payments made by the Patient of child support shall not be deducted from the Patient's household annual gross income.

(b) Household annual gross income for Patients who own their own business shall be demonstrated by the Patient's most recent federal income tax returns, including all schedules that support adjusted gross income per the tax return. Depreciation and amortization of goodwill claimed for Patient's business will be added to the household annual gross income for the purpose of computing income eligibility.

(c) The Patient may provide alternate forms of verification of annual gross income for the previous twelve months in lieu of or in addition to the most recent federal income tax return, at the discretion of Social Services Division, on behalf of the HCA Administrator.

2. NUMBER OF FAMILY MEMBERS.

(a) Dependent family members under eighteen (18) years of age will be counted in determining the number of family members in the household. Their earned

income, if any, will be exempt in determining the household annual gross income of the Patient. Their unearned income, including but not limited to social security, SSI or welfare benefits, shall be included in determining their parents' annual gross income.

(b) Dependent family members eighteen (18) years of age or older will be counted in determining the number of family members in the household and such dependent family member's annual gross income shall be included in the Patient's household annual gross income unless the dependent is a student, in which case the dependents income will not be countable. If such a dependent family member is the Patient, only his/her annual gross income shall be counted in determining the Patient's household annual gross income and the number of family members will be determined as one (1).

(c) A non-dependent child under 18 years of age who is the Patient and who is self-supporting and living with a family unit will be considered as an autonomous adult with the child's income considered separately toward the determination of the child's annual gross income.

3. FINANCIAL OR IN-KIND SUPPORT. Non-dependent, adult household or non-household member(s) who provide financial or in-kind support for the living expenses of the Patient shall sign and submit to Social Services Division, on behalf of the HCA Administrator, a sworn statement indicating the amount of the support to the Patient. The value of such support shall be included in the determination of the Patient's gross annual income.

4. ASSETS. Patients are required to complete the financial section, listing their liabilities and liquid assets, on the Application to determine financial eligibility for HCA Fund assistance. Patients must use any liquid assets in excess of Ten Thousand ($10,000) per household, or Five Thousand ($5,000) in the case where a Patient is the only member of his/her household, as payment against any bills eligible under HCAP before Social Services Division will consider payment of these bills, on behalf of the HCA Administrator.

E. EXTENSION OF BENEFITS. The HCA Administrator, with the approval of the County Manager and 3-day advance notice to the Board, may extend benefits in exceptional cases where eligibility requirements are otherwise met, but maximum payments are exceeded upon a finding that a strict, mechanical application of any provision would, to a reasonable degree of medical probability based on medical opinions provided to the HCA Administrator, result in an immediate and substantial limitation of the individual's ability to perform major life activities such as caring for oneself, working, performing manual tasks, walking, seeing, hearing, speaking, breathing, or learning. The fiscal condition of the HCA Fund will be a consideration in determining whether to extend benefits pursuant to this section. The burden of persuasion for such finding shall be upon the Patient requesting the extension of benefits and must be supported by written certification from the Patient's treating physician that such circumstances exist and the basis for such conclusion. The HCA Administrator shall, in all cases, specifically state the reasons for granting an extension of benefits.

SECTION V. CONFIDENTIALITY; AND APPEALS.

A. CONFIDENTIALITY. Confidentiality of a Patient's personal health information shall be maintained at all times in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

B. CLAIM DENIAL AND APPEAL PROCESS.

1. Social Services Division, on behalf of the HCA Administrator, shall inform the Patient in writing within thirty (30) days after his/her Application has been denied or his/her claim payment has been denied. The Division, on behalf of the HCA Administrator, shall state the reasons for the denial and shall inform the Patient of the appeal rights afforded by this HCAP Policy. The Patient may appeal to the Board an adverse decision by either the Division or the HCA Administrator not later than thirty (30) days after the date of the written notification of denial. Such requests must be in writing and cite specific reasons for appeal including citation to specific provisions of this HCAP Policy in support of the appeal. The appeal may not seek a waiver of any provision of this HCAP Policy. The appellant or his representative may appear at the hearing on the appeal, which may be held in closed session in accordance with the law. The Board will review the basis for the appeal including any new information and may deliberate privately. The Board will render a decision on the appeal in open session of the Board meeting. If the appellant does not appear for the hearing on the appeal, the Board will proceed to a determination on the appeal and the HCA Administrator will notify the appellant of the Board's decision in writing. Appeal hearings shall be held within forty-five (45) days after receipt of a written appeal of a denied claim.

2. Any eligible HCAP Provider aggrieved by a decision of the Board or its designee may appeal to the district court as provided in Section 27-5-12.1, N.M.S.A. 1978.

SECTION VI. PROVIDERS.

A. ELIGIBLE PROVIDERS. The following providers of health care services who have entered into valid provider agreements with the Board, on terms and conditions acceptable to the HCA Administrator and consistent with this HCAP Policy and the Act, and who agree to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are eligible to receive payment from the HCA Fund, within the payment limitations stated in Section II.B of this HCAP Policy:

1. Ambulance service providers that are licensed, certified or registered by the appropriate New Mexico state agency. Reimbursements of claims will be paid in an amount not to exceed a predetermined allocation, determined by the County, based on fund availability.

2. Other medical, dental, pharmaceutical, and behavioral health care provider(s) with whom the County has contracted and selected to provide agreed upon services to detainees of Los Alamos County. Reimbursements of claims will be paid in an amount not to exceed a predetermined allocation, determined by the County, based on fund availability.

3. Other medical, dental, and behavioral health care provider(s) with whom the County has contracted and selected to provide agreed upon services to residents of Los Alamos County. Reimbursements of claims will be paid in an amount not to exceed a predetermined allocation, determined by the County, based on fund availability.

As of July 1, 2014, Hospitals formerly designated as Sole Community Provider (SCP) Hospitals receive payment for services directly through New Mexico State's Human Services Department and no longer have any contract with the Board as an eligible HCAP Provider. As such, the Board no longer accepts claims submitted by these Hospitals.

B. CLAIMS PREPARATION AND VERIFICATION. An eligible HCAP Provider shall submit claims to the Social Services Division, on behalf of the HCA Administrator, and shall ensure claims submitted on behalf of eligible HCAP Patients are as payment of last resort.

C. DISCLOSURE. Eligible HCAP Providers may be required to provide to Social Services Division, on behalf of the HCA Administrator, reports, financial statements, billing, or other information deemed necessary to processing a claim for eligibility under the HCAP Policy.

D. LIMITATIONS ON COLLECTIONS. Once a Patient's claim has been deemed eligible for payment from the HCA Fund, an eligible HCAP Provider shall not pursue any further collection of any portion of the Patient's claim from any person or party. Such payment from the HCA Fund shall be deemed by the eligible HCAP Provider as payment in full.

E. PROVIDER'S RESPONSIBILITY.

1. It is the responsibility of the eligible HCAP Provider to verify with the Social Services Division, on behalf of the HCA Administrator, that a Patient meets the eligibility requirements of HCAP, as stated in Section II.A, prior to submitting a claim to the HCA Fund for payment. Once eligibility has been verified, Social Services Division, on behalf of the HCA Administrator, shall then process payment of submitted claims.

2. It is the responsibility of the eligible HCAP Provider to submit claims to Social Services Division, on behalf of the HCA Administrator, no later than 120 days past the date of service.

3. At the request of the Social Services Division, on behalf of the HCA Administrator, an eligible HCAP Provider must provide evidence of licensure under the laws of the State of New Mexico, or any state or other governmental entity in which the Provider operates; and also provide any other information or data that may be deemed necessary by the Board to indicate that medically necessary services have been rendered.

4. As part of any audit of HCAP, eligible HCAP Providers may also be audited to ensure their compliance with the HCAP Policy.

SECTION VII. PAYMENT OF CLAIMS.

A. PAYMENT RATES.

1. Payment of HCA Funds shall be made only to eligible HCAP Providers, only in payment for eligible services under this HCAP Policy, and subject to the limitations imposed herein. Claims shall be submitted on itemized bills or on standardized medical claim forms acceptable to Social Services Division, on behalf of the HCA Administrator. Total charges to eligible Patients, prior to any adjustment to a final payment rate, shall not exceed the normal charges to non-indigent patients.

2. Payment of HCA Funds to eligible HCAP Providers shall be reimbursed at a rate not to exceed the Medicaid rate, where a Medicaid rate has been established. Where a Medicaid rate has not been established, HCAP Providers shall be reimbursed at the rates established by the State of New Mexico and posted on the New Mexico Human Services Department's website.

3. The HCA Administrator may initiate an independent medical review to determine if any claim for treatment is appropriate. The HCA Administrator may contract for this service, as long as the reviewers are independent of the parties to the claim.

4. The HCA Board authorizes the HCA Administrator to approve payment to eligible HCAP Providers only after determining that: 1) the Patient for whom the claim is made is an eligible Patient; 2) the costs claimed are allowable; and 3) there is compliance by the eligible HCAP Provider and the eligible Patient with this HCAP Policy and with the Act.

5. Except as otherwise authorized by this HCAP Policy, all claims approved pursuant to this HCAP Policy shall be paid to the eligible HCAP Provider within thirty (30) days after approval based upon availability of funds.

B. HCA FUNDS EVIDENCE OF PAYER OF LAST RESORT. Eligible HCAP Providers shall provide evidence that all other possible sources of payment are unavailable for payment of their claims, such as but not limited to health insurance, workers compensation, Medicaid and/or Medicare. HCA Funds may then be approved for payment as a payer of last resort, consistent with the provisions of this HCAP Policy.

C. CLAIMS ELIGIBLE FOR PAYMENT. Subject to the payment limitations described in Section II.B of this HCAP Policy, claims eligible for payment to eligible HCAP Providers on behalf of eligible Patients include:

1. Care and treatment that is medically necessary. Medically necessary includes acute care related to the diagnosis and/or treatment of illness or injury or emergency medical services.
2. Ambulance transportation expense is limited to the distance to the "nearest" acute care hospital where the needed medical care can be provided regardless of where thepatient requests to be sent or actually is transported. Subsequent transports for treatment may be eligible for payment if medically necessary and requested by the attending physician.
3. Behavioral health and alcohol or substance abuse treatment services.

D. CLAIMS NOT ELIGIBLE FOR PAYMENT. Claims including, but not limited to, the following are not eligible for payment; 1) surgery or treatment not medically necessary; 2) physician care by a physician not employed or contracted by an eligible HCAP Provider, or otherwise billed by the hospital; 3) services not rendered by an eligible HCAP Provider; 4) prescribed medication and over the counter medication; 5) elective surgery or treatment; 6) any claim for less than Twenty-five Dollars ($25.00); 7) claims for reimbursement of payments made by the Patient directly to the HCAP Provider and 8) services rendered through a hospital qualified to receive Safety Net Care Pool funds administered by the State Human Services Department, and to which the Board directs payment of HCA Funds in conformity with applicable law.

E. OVERCHARGES. Any eligible HCAP Provider found billing for services not rendered or not eligible for payment, overcharging, billing for “no-shows,” billing greater than the normal charges to other patients for itemized services paid by HCA Fund, billing more than one insurance company or government agency for the same services, or engaging in other similar activities is in violation of the provisions of the HCAP Policy and is in breach of contract with the Board and shall not receive further payment of HCA Funds. The provider shall be given the opportunity to provide its justification and documentation to the HCA Administrator and the Board prior to any action being implemented. The Board, or the HCA Administrator on behalf of the Board, may, at its discretion, carry out an investigation to determine overcharges or improper billing. An eligible HCAP Provider shall provide to the Social Services Division, on behalf of the HCA Administrator, information requested to verify charges. The HCA Administrator may decline to approve claims made by an eligible HCAP Provider suspected of violating of this HCAP Policy until such time as an investigation is complete.

F. PAYMENT LIMITED TO AVAILABLE FUNDS. The Board will pay claims that have been approved pursuant to this HCAP Policy to eligible HCAP Providers provided there are available monies in the HCA Fund. The HCA Administrator will make payment based upon the order in which claims are approved. If the HCA Fund is exhausted, excluding the allotment for administrative and planning costs as specified in the Act under Section 27-5-6(B), NMSA 1978, any outstanding claims will also be paid based upon the order in which they have been approved, as soon as monies become available in the HCA Fund.

G. SUBROGATION. Payment to an HCAP Provider, on behalf of an eligible Patient shall operate as an assignment to the Board of any cause of action such an eligible Patient may have against third parties to the extent of the payment from the Fund to the HCAP Provider.

GLOSSARY

The following terms are defined to be used for the purpose of the Incorporated County of Los Alamos Health Care Assistance Policy adopted by the Board, the 27th day of June, 2014, and effective July 1, 2014, regardless of common usage of such terms, or usage for other purposes.

Acute Care means by order of a physician, care of a patient placed in hospital for emergency care; scheduled surgery requiring inpatient operating room, therapeutic procedures which cannot be performed on an outpatient basis; monitoring of drugs; or specialized therapy on an around-the-clock basis as defined by New Mexico Professional Review Organization and does not include ineligible medical services as specified by the provisions of this HCAP policy.

Adult means an individual who is eighteen (18) years or older, or an individual under eighteen (18) years old who is legally emancipated.

Alcohol or Substance Abuse Service means a service provided to a patient for treatment of alcohol or substance abuse that meet the credentialing and/or licensing standards set forth by New Mexico regulatory agencies.

Ambulance Provider or Ambulance Service means a specialized carrier based within the state authorized under provisions and subject to limitations as provided in individual carrier certificates issued by the public regulation commission to transport persons alive, dead or dying en route by means of ambulance service. The rates and charges established by public regulation commission tariff shall govern as to allowable cost. Also included are air ambulance services approved by the Board. The air ambulance service charges shall be filed and approved pursuant to Subsection D of Section 27-5-6 NMSA 1978 and Section 27-5-11 NMSA 1978.

Assets means cash, or other assets that can quickly or easily be converted to cash, such as checking and savings account balances; retirement accounts; stocks and bonds; equity in real estate, other than residence, based on County Assessor's appraised value; and the cash value of any life insurance policy of a Patient.

Behavioral Health Service means a service or services provided to a patient for treatment of substance abuse or mental health issues that meet the credentialing and/or licensing standards set forth by New Mexico regulatory agencies.

Board means the Los Alamos County Health Care Assistance Board (formerly the Indigent Hospital and County Health Care Board).

Costs means all eligible HCAP claims for providing health care services, pursuant to this HCAP Policy, on behalf of an eligible Patient.

Dependent means a person: (1) whose income is less than the gross amount per year required by the Internal Revenue Service for filing a federal income tax return; and/or (2) who receives over one-half of his support from his parent or custodian; and/or (3) who is legally married and does not file a joint return with his/her spouse.

Fund means the county Health Care Assistance Fund.

Health Care Provider means: (1) an alcohol and drug treatment facility or program; (2) a behavioral or mental health center or program; (3) a New Mexico licensed, certified or registered

health care practitioner, medical doctor or osteopathic physician, and (4) an Ambulance provider as defined above.

Hospital means a hospital qualified to meet the provisions of the federal Centers for Medicare & Medicaid Services guidelines, or an acute care general or limited hospital licensed by the State Department of Health that is qualified, pursuant to rules adopted by the state agency primarily responsible for the Medicaid program, to receive distributions from the Safety Net Care Pool (SNCP).

Indigent Patient means an individual who makes application for HCA Fund assistance for payment of bills in which an eligible HCAP Provider has rendered medical care, ambulance transportation or behavioral health care services and who can normally support him/herself and his/her dependents on present income and assets available to him/her but, taking into consideration this income and those assets and his/her requirement for other necessities of life for him/herself and his/her dependents, is unable to pay the cost of these bills.

Medically Necessary means clinical and rehabilitative, physical, mental or behavioral health services as defined in NMSA Chapter 24: Health and Safety, Article 7A: Uniform Health-Care Decisions, 24-7A-1 through 24-7A-18

Safety Net Care Pool means the funding pool set aside for qualified hospitals that is administered by the State Human Services Department and to which the Board directs payments from the HCA Fund each quarter as required by law.