

# Know Your Rights with Medical Bills

## Low-income patients in New Mexico can no longer be sued or sent to collections for a medical bill!

- Hospitals and providers must check if you have a low income, before suing you or sending you to collections. **They must contact you at least three times.**
- **At any time, you can tell the billing department or collection agency you have a low income and can't be sued or sent to collections.**
- You don't need to show income documents to prove you're protected. **A signed statement about your income must be accepted.**
- Income below the following levels is considered "low income" (before taxes and deductions):

| Household size           | 1       | 2       | 3       | 4       | 5+                                     |
|--------------------------|---------|---------|---------|---------|--|
| Monthly income is under: | \$2,609 | \$3,525 | \$4,442 | \$5,359 | Add \$917 for every additional person. |

**Hospitals, urgent cares, and other clinics must check if patients qualify for programs that help with medical costs and help them sign up.**

- *This includes programs like Medicaid, indigent care, and financial assistance.*
- *Indigent care programs, like UNM Care, cannot deny assistance based on immigration status.*

### **By law, your medical bill must have the following information:**

1. The date(s) you received care.
2. If you have insurance.
3. If the insurance was billed for your care at the hospital, urgent care, or clinic.
4. How much you owe.
5. If the hospital, urgent care, or clinic checked if you qualify for programs (such as Medicaid) that could help with healthcare costs.



***Patients do not have to agree to a payment plan to receive these protections.***



**ATTESTATION OF INDIGENCY**

1.  I am the patient. My name is: \_\_\_\_\_  
     My date of birth is: \_\_\_\_\_  
      I am not the patient.
2.  I take care of the patient. The patient's name is: \_\_\_\_\_  
     a. My relationship to the patient is: parent grandparent guardian  
          Other: \_\_\_\_\_  
     b. The patient's date of birth is: \_\_\_\_\_
3.  I am over 18 years of age. OR I am an emancipated minor.
4.  I am competent to make this attestation.
5. My current or projected **annual** income, or the patient's current or projected **annual** household income, is at or below 200% of federal poverty guidelines. [Find the household size, then look at the annual income directly below that number. If the annual income is less than or equal to that annual income, then check that box.]

|                       |                                      |                                       |                                      |                                      |                                       |                                      |                                      |
|-----------------------|--------------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|
| <b>Household size</b> | 1                                    | 2                                     | 3                                    | 4                                    | 5                                     | 6                                    | 7*                                   |
| <b>Annual Income</b>  | <input type="checkbox"/><br>\$31,300 | <input type="checkbox"/><br>\$ 42,300 | <input type="checkbox"/><br>\$53,300 | <input type="checkbox"/><br>\$64,300 | <input type="checkbox"/><br>\$ 75,300 | <input type="checkbox"/><br>\$86,300 | <input type="checkbox"/><br>\$97,300 |

6. I don't know the patient's or my annual income. My **monthly** income, or the patient's **monthly** household income, is at or below 200% of federal poverty guidelines. [Find the household size, then look at the monthly income directly below that number. If the monthly income is less than or equal to that monthly income, then check that box.]

|                       |  |  |  |  |  |  |  |
|-----------------------|--|--|--|--|--|--|--|
| <b>Household size</b> | 1                                      | 2                                      | 3                                      | 4                                      | 5                                      | 6                                      | 7*                                     |
| <b>Monthly Income</b> | <input type="checkbox"/><br>\$2,608.33 | <input type="checkbox"/><br>\$3,525.00 | <input type="checkbox"/><br>\$4,441.67 | <input type="checkbox"/><br>\$5,358.33 | <input type="checkbox"/><br>\$6,275.00 | <input type="checkbox"/><br>\$7,191.67 | <input type="checkbox"/><br>\$8,108.33 |

\*For family units of more than 7, add these amounts for each additional household member:

- \$11,000/year if using the annual income levels
- \$917/month if using the monthly income levels

7. I attest that the information that I am providing for myself, or the patient, is true and correct. I understand that I am providing this information so that my medical provider will not sue me or engage in collection actions against me.

\_\_\_\_\_  
(Signature of Patient or Parent/Legal Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name of Patient or Parent/Legal Guardian)

Address: \_\_\_\_\_