HEALTH CARE AUTHORITY

PLEASE COMPLETLEY FILL OUT THE FORM
(NOT DOING SO MAY CAUSE A DELAY)

MEDICALLY FRAGILE WAIVER REGISTRATION FORM

HOME AND COMMUNITY BASED (HCBS) WAIVERS

For official use only

Effective 07/22/2025

date stamp

Primary Medical Diagnosis: Age of Onset of Medical Diagnosis:

Intellectual/Developmental Disability Diagnoses: Age of Onset of I/DD:

APPLICANT INFORMATION				SEX	***Language Preference:***
Name – Last	*First*		*Middle Initial*	☐ M ☐ F	*Date of Birth*
Street Address	*City*	*State*	*Zip Code*		*Social Security Number*
Mailing Address (if different from street address)	*City*	*State*	*Zip Code*		*Telephone Number*
County of Residence	*County in which services are requested (if different from residence)*				*E-mail Address*

First time applying? ☐ Yes ☐ No ☐ Don't know

Currently receiving Medicaid? ☐ Yes ☐ No

Name and relationship of individual submitting registration form:

1. LEGAL REPRESENTATIVE INFORMATION*

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Agency

*Anyone other than the parent(s) of a minor child MUST include copies of documents that provide evidence of legal authority to act on behalf of the applicant.

Name – Last	*First*			*Agency Name (if corporate guardian)*
Street Address	*City*	*State*	*Zip Code*	*Primary Telephone Number*
Mailing Address (if different from street address)	*City*	*State*	*Zip Code*	*E-mail Address*

2. ☐ AUTHORIZED REPRESENTATIVE OR ☐ ALTERNATIVE/EMERGENCY CONTACT*

*Please ensure that an Authorization for Release of Information is provided for this person.

Name – Last	*First*			*Relationship to applicant:*
Street Address	*City*	*State*	*Zip Code*	*Primary Telephone Number*
Mailing Address (if different from street address)	*City*	*State*	*Zip Code*	*Other Number*

Si necesita ayuda o información en español, por favor llámenos al número 1-505-328-6081.
If you are a person with a disability and you require this information in an alternative format or require special accommodation to participate in registration or services, Please call 1-800-283-8415. Once completed please fax the form to 505-841-2987 or mail it to 5300 Homestead Rd NE, Suite 226, Albuquerque, NM 87110

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Registration Date:	*Staff completing registration:* Initials & Date:	*Staff entering registration in CR:* Initials & Date:	Region: ☐NWRO ☐METRO ☐SERO ☐NERO ☐SWRO