



HEALTH CARE
AUTHORITY

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

MEDICALLY FRAGILE WAIVER REGISTRATION FORM

HOME AND COMMUNITY BASED (HCBS) WAIVERS

<i>For official use only</i>
<i>Effective 06/10/2026</i>
<i>date stamp</i>

Primary Medical Diagnosis:	Age of Onset of Medical Diagnosis:
Intellectual/Developmental Disability Diagnoses:	Age of Onset of I/DD:

APPLICANT INFORMATION

<i>Name – Last</i>			<i>First</i>	<i>Middle Initial</i>	SEX <input type="checkbox"/> M <input type="checkbox"/> F	<i>Language Preference:</i>
<i>Street Address</i>			<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Social Security Number</i>
<i>Mailing Address (if different from street address)</i>			<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>
<i>County of Residence</i>		<i>County in which services are requested (if different from residence)</i>			<i>E-mail Address</i>	

First time applying? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Currently receiving Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name and relationship of individual submitting registration form:

1. LEGAL REPRESENTATIVE INFORMATION*

<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> 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.		
<i>Name – Last</i>		<i>Agency Name (if corporate guardian)</i>
<i>Street Address</i>		<i>Primary Telephone Number</i>
<i>Mailing Address (if different from street address)</i>		<i>E-mail Address</i>

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

*Please ensure that an Authorization for Release of Information is provided for this person.		
<i>Name – Last</i>		<i>Relationship to applicant:</i>
<i>Street Address</i>		<i>Primary Telephone Number</i>
<i>Mailing Address (if different from street address)</i>		<i>Other Number</i>

*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, email to HCA-MedicallyFragileWaiver@hca.nm.gov or mail it to 5300 Homestead Rd NE, Suite 226, Albuquerque, NM 87110***

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Registration Date:	<i>Staff completing registration:</i>	<i>Initials & Date:</i>	<i>Staff entering registration in CR:</i>	<i>Initials & Date:</i>	Region: <input type="checkbox"/> NWRO <input type="checkbox"/> METRO <input type="checkbox"/> NERO	<input type="checkbox"/> SERO <input type="checkbox"/> SWRO
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