



APPLICATION/REDETERMINATION of ELIGIBILITY for MEDICAL ASSISTANCE  
Of Aged, Blind and Disabled Individuals

If you need help with this form just ask your caseworker. Free interpreters are available. Si necesita ayuda para completar este formulario, pídale su trabajador(a).  
Intérpretes están disponibles gratuitamente.

**PLEASE READ ALL QUESTIONS.** The applicant is the person who wants Medicaid. If the applicant is married, we need certain information about his/her spouse. If the applicant is a child, we need certain information about his/her parents. We refer to the applicant on the form by using the words "you" or "your." The answers given will be used to determine eligibility. You may ask a friend, relative or someone at the county office for help in completing the application. If information is incomplete or is unclear, you will be asked to provide further information.

**This application is for:**

- Nursing Home  ICF-MR  Medically Fragile Waiver  Aids Waiver  Disabled & Elderly Waiver  Developmentally Disabled Waiver  Brain Injury

**1. APPLICANT INFORMATION**

Name-Last		First	Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Age	Birth Date / /
Mailing address- Street No./PO Box /R. Rt.			City	State	Zip Code	Telephone Number
Home address or directions to your home:						
Are you in a nursing home or hospital?		If, YES, Name of Facility:				
<input type="checkbox"/> YES <input type="checkbox"/> NO						
Are you a resident of another state?			If, YES, name state where you are a resident:		Do you intend to remain in New Mexico? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> YES <input type="checkbox"/> NO						
Social Security Number - -	Medicare Claim Number - - -	Railroad Retirement Number	Indian Census Number			
<b>CITIZENSHIP</b>			Registration Number (if legal alien)			
United States citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO		If, NO, have you been legally admitted for US Residence? <input type="checkbox"/> YES <input type="checkbox"/> NO				
<b>MARITAL STATUS – Check one</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED or LEGALLY SEPARATED <input type="checkbox"/> SEPARATED – Without legal action						

**2. SPOUSE INFORMATION**

Name – Last		First	Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Age	Birth Date / /
Social Security Number - -	Medicare Claim Number - - -	Railroad Retirement Number	Indian Census Number			
Mailing address- Street No./PO Box /R. Rt.			City	State	Zip Code	Telephone Number
Home Address or directions to your home:						
Is the spouse in a nursing home?		If, YES, Name of Facility:				
<input type="checkbox"/> YES <input type="checkbox"/> NO						

<b>FOR COUNTY OFFICE USE ONLY</b>	
GEO	ADMIN
Date Received / /	
<b>CATEGORIES</b>	
ASSIGNED TO:	
REFERRAL TO DDS: ISD 305 COMPLETED	
Date Submitted / /	
<b>SSI</b>	
Eligible Date / /	
Ineligible Date / /	
Referral Date / /	
<b>SCANS</b> SDX _____ WDX _____	
TPQY Mailed / /	

**If you have a disability:** If you are a person with a disability and you need 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 TDD 1-800-609-4TDD or through the New Mexico Relay System TDD at 1-800-659-8331. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (04/23/01)



KIND of INCOME	\$ Net Amount per Month
SMALL BUSINESS	
OTHER SELF-EMPLOYMENT	

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**6. RESOURCES**

Do you or your spouse/parent own any of the following money or property? Enter the value.

DESCRIPTION	Value	
	Applicant	Spouse/Parent
STOCKS/BONDS/CDs		
CASH/CHECKING/SAVINGS, or MONEY MARKET ACCOUNTS		
LAND- (include lots, acres, grazing permits and mining claims-type, number and location, mineral deeds)		
IRAs, KEOGH PLAN		
LIFE ESTATE		

DESCRIPTION	Value	
	Applicant	Spouse/Parent
BUILDINGS – Other than home		
LIVESTOCK (include Type & Number)		
TOOLS, EQUIPMENT or OTHER valuable item (s) (describe)		
REAL ESTATE CONTRACTS		
ANNUITIES		
OTHER		

Do you or your spouse/parent own cars, trucks or other vehicles?  YES  NO

If YES, complete the following:

MAKE and MODEL (Other description)	YEAR

OWNERSHIP of a HOME	ADDRESS	EQUITY VALUE	MARKET VALUE
Do you or your spouse own a home? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Are you or your spouse buying a home? <input type="checkbox"/> YES <input type="checkbox"/> NO			

Equity Value \$ \_\_\_\_\_

Home Excluded  YES  NO

Are you, your spouse, minor child, or disabled child currently living in this home? <input type="checkbox"/> YES <input type="checkbox"/> NO		If no, do you intend to return? <input type="checkbox"/> YES <input type="checkbox"/> NO				
NAME (s) of OTHER PERSON (s) in the home	RELATIONSHIP to YOU	BIRTHDATE			CHECK IF:	
		Mo.	Day	Year	Blind	Disabled

6. **RESOURCES** - CONTINUED

Do you or your spouse/parent(s) own life insurance policies?  YES  NO

If YES, complete the following:

NAME and ADDRESS of COMPANY	POLICY NUMBER	PERSON(s) INSURED	FACE VALUE	CASH VALUE

Do you have an account which is intended for burial expenses, a prepaid burial contract, or anything else to be used for burial?  YES  NO

7. **TRUSTS**

Have you or your spouse set up a trust? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, when?	DATE / /
Was this trust set up as a result of a lawsuit? <input type="checkbox"/> YES <input type="checkbox"/> NO		

8. **TRANSFERS**

Have you or your spouse transferred anything of value in the past 60 months? This includes, but is not limited to, gifts, jointly held accounts or deeds where your name was removed, quit claim deeds, transferred mineral rights, transferred certificates of deposit, cash, savings, stocks, bonds, or anything else of value.  YES  NO

ITEM TRANSFERRED	TO WHOM TRANSFERRED	DATE OF TRANSFER	VALUE
		/ /	
		/ /	
		/ /	

9. **MEDICAL/HEALTH INSURANCE**

Are you covered by an insurance plan(s)?  YES  NO If YES, name the insurance companies:

Is money taken from your Social Security or Railroad Retirement check for Medicare?  YES  NO

Insurance Claim Number	Premium Amount \$	Type of Payment <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Biannually <input type="checkbox"/> Other:
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**APPLICATION for RETROACTIVE MEDICAL PAYMENTS** PLEASE READ CAREFULLY

Do you have unpaid bills for medical services received in the last three months?  YES  NO

If you do not understand the purpose of this section, please ask your worker to explain it to you. If you are approved for payment of retroactive medical bills, be sure to advise your doctor, hospital or other medical provider so that they can submit their bills for payment as soon as possible.

**YOU CAN REGISTER TO VOTE HERE**

If you are **NOT** registered to vote where you live now, would you like to register to vote here today?  YES  NO (Please check one)

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, 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. 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 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 political preference, you may file a complaint with the Office of the Secretary of State, 419 State Capitol, Santa Fe, NM 87503, (phone: 1-800-477-3632).

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**Life Insurance**

Total Face Value  
\$ \_\_\_\_\_

Excluded  YES  NO

Date Request mailed to company

/ /

Date Verification received

/ /

Total Cash Value  
\$ \_\_\_\_\_

Prepaid Contract Irrevocable  YES  NO

Casket value \$ \_\_\_\_\_

Vault value \$ \_\_\_\_\_

Opening/closing \$ \_\_\_\_\_

Cemetery lot \$ \_\_\_\_\_

Headstone \$ \_\_\_\_\_

**TOTAL** \$ \_\_\_\_\_

Copy of Trust For Legal Interpretation Date

/ /

Legal Determination Received Date

/ /

Completed TPL Form

/ /

ISD 333 Completed

/ /

I agree to provide information to the Human Services Department (HSD) which is needed to determine if I, (or the person(s) for whom I am applying), can get Medicaid. I agree to let HSD contact other persons or agencies which know about us to get information which I may not be able to give or to prove.

**PERMISSION TO RELEASE MEDICAL INFORMATION** - I give permission for medical information about me, or about the person(s) for whom I am applying for Medicaid, to be released to HSD. I understand that such information includes both social and medical history and the results of any laboratory tests or examinations.

I understand that this information is needed in connection with assistance for which I am applying and will be used by HSD's contractors who review medical services and pay Medicaid bills.

**ASSIGNMENT OF MEDICAL SUPPORT** - I understand that by signing this application I am assigning to HSD my rights, and/or the rights of the individuals for whom I am applying for Medicaid, whose rights I can legally assign, to payment for medical support and other third party payments. I agree to cooperate with HSD in getting medical support and payments. I understand that this assignment and my cooperation are necessary so that I, and/or those persons for whom I am applying, can get Medicaid.

I understand that I must give HSD any money I receive for medical services which have already been paid for by Medicaid. If I fail to do so, I, or the person(s) for whom I am applying, may lose Medicaid coverage for at least one year AND until the amount owed to Medicaid has been paid back in full.

**ASSIGNMENT OF CHILD SUPPORT RIGHTS** - I understand that by signing this application I am assigning to HSD any rights to child support to which I am entitled on behalf of any child for whom I am applying or receiving Medicaid benefits. When child support is received, I understand that one third (1/3) of the amount is disregarded in determining eligibility. If this application is for Institutional Care Medicaid, I understand that the entire amount of child support is used to figure the amount of the applicant's income which goes to help pay the nursing home.

**TRUSTS** - I understand that if I, or the person(s) for whom I am applying, have set up a trust, or are the beneficiaries of a trust, I must give HSD a copy of the trust document, including all attachments and related information. HSD will analyze the trust to see if it affects the Medicaid benefits for which I am applying.

**ESTATE RECOVERY**- I understand that, after my death, the HSD can file a claim against my estate to recover the amounts that the state pays or paid on my behalf for medical assistance provided under the Medicaid program. This process is called "Estate Recovery." "Estate Recovery" is required by federal and state law where Medicaid recipients are fifty-five (55) years of age or older and the state makes medical assistance payments on their behalf for nursing facilities services, home and

community based services, and/or related hospital and prescription drug services. The amount recovered by HSD will not exceed the amount of medical assistance payments made on behalf of the Medicaid recipient.

**REPORTING CHANGES** – I understand that the information I have given on this application is used to see if I, or the person(s) for whom I am applying, can receive Medicaid. I understand that if the information I have given to HSD changes, I must report the new information to my worker within ten (10) days.

*Examples of changes which must be reported are:*

- Changes in the amount of income received by me or members of my family whose income was used in figuring my eligibility or changes in the amount of income belonging to the person(s) for whom I am applying.
- The amount of real or personal property (such as land or money) owned by me or the person(s) for whom I am applying, goes up or down.
- I or the person for whom I am applying, move into or out of a nursing home or hospital or move into a different nursing home, return home or move to the home of another. I understand I must also report if I, or the person(s) for whom I am applying, move out of New Mexico.
- I understand I must report when a person who has needed care in a hospital or nursing home or who needed another person to care for him/her no longer needs such care.

I understand that I am responsible for reporting changes that may affect whether I, or the person(s) for whom I am applying, can get Medicaid. No other person or agency is responsible for reporting these changes. I understand that purposely failing to report information such as that listed above within ten (10) days is fraud. I understand that HSD can take legal action to get back amounts that Medicaid paid on behalf of persons who did not qualify for these benefits. I also understand that anyone who helps to deceive HSD is subject to criminal penalties under the law.

**RIGHT TO A HEARING** - I understand that, if a decision on my application is not reached within thirty (30) days, HSD will send me a letter explaining the delay. I understand that I may ask for a hearing if my application is denied, delayed or Medicaid benefits are stopped.

I also understand that I may request a hearing if I am not satisfied with any action by HSD or if I think I have been discriminated against because of race, color, national origin, religion, sex, age, creed or handicap. I also understand that I may have an attorney represent me at a hearing and that HSD will NOT pay for the cost of these legal services.

**NOTICE:** *The law provides for a fine of up to \$5,000 or imprisonment of up to 10 years for anyone who helps take anything of value, including public assistance, by deliberately withholding or giving false information.*

<b>I UNDERSTAND THE QUESTIONS ON THIS APPLICATION. MY ANSWERS ARE CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE</b>				
<i>Applicant's Signature</i>	<i>Signature of Witness (Witnessed only if applicant signs by mark or thumbprint)</i>		<i>Date</i>	
<i>Signature of Applicant's Representative</i>	<i>Signature of Witness</i>		<i>Date</i>	
<i>Mailing Address of Representative – Street No./PO Box/R.Rt.</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Work Telephone Number</i>
				<i>Home Telephone Number</i>