

## New Mexico Medicaid Estate Recovery Program

This document will provide a general overview of the New Mexico Medicaid Estate Recovery Program. Individual circumstances will vary and may affect how applicable laws and policies apply.

### FREQUENTLY ASKED QUESTIONS ABOUT NEW MEXICO MEDICAID ESTATE RECOVERY PROGRAM

#### **1. What is the New Mexico Medicaid Estate Recovery Program?**

The Estate Recovery Program is a federally mandated process requiring the New Mexico Health Care Authority (HCA), Medical Assistance Division (MAD), to seek repayment from the estate of certain deceased Medicaid members for long-term care (LTC) services and related medical costs paid on their behalf.

#### **2. Who is subject to New Mexico Medicaid Estate Recovery Program?**

New Mexico Medicaid Estate Recovery Program applies to Medicaid members who were age 55+ and received LTC services, including nursing facility care, home and community-based services (HCBS), and related hospital and prescription drug services. On the signed application, the member acknowledged they understand their estate may be subject to New Mexico Medicaid Estate Recovery.

#### **3. Who is responsible for administering the New Mexico Estate Recovery Program?**

The HCA-MAD is responsible for maintaining an Estate Recovery Program. The HCA-MAD contracts with Heath Management Systems (HMS) to conduct Estate Recovery operations. HMS is located in Phoenix, AZ, and will work directly with estate representatives to resolve an Estate Recovery case.

#### **4. What LTC services are subject to Estate Recovery?**

LTC services include nursing facility services, home and community bases services, and related hospital and prescription drug services. Member must be 55+ at the time of

death and receiving LTC services through New Mexico Medicaid.

**5. What property is considered part of the estate?**

The estate includes real property and personal property that are subject to probate or estate administration under New Mexico law.

**6. Are there exemptions from New Mexico Estate Recovery Program?**

Yes. Exemptions apply to certain Native American income, resources, and property, Medicare Savings Programs, and Achieving a Better Life Experience (ABLE) accounts.

**7. What is an Undue Hardship Waiver?**

Some estates may qualify for an Undue Hardship Waiver. A waiver may be granted when estate recovery would cause significant financial hardship to heirs, such as loss of a primary residence. Waivers are not automatic, are evaluated on a case-by-case basis and must be requested with supporting documentation.

**8. Can estate recovery claims be settled or compromised?**

Yes. The HCA-MAD may compromise, settle, or waive estate recovery claims when doing so is in the best interest of the state and consistent with state and federal law.

**9. Are heirs personally responsible for New Mexico Medicaid Estate Recovery?**

No. Heirs are not personally liable for repayment. The HCA-MAD files a claim against the Medicaid member's estate.

**10. Is an estate with no assets subject to Estate Recovery?**

If there are no assets in the estate, the HCA-MAD will not seek recovery. The HCA-MAD will only seek recovery on assets subject to probate and not exceeding the value of the estate.

**11. What document will the estate representative receive regarding Estate Recovery?**

At the end of this document, there are a few examples of what you can expect to receive from HMS.

**12. Will the Estate Recovery Program place a lien on my property?**

At this time, HCA- MAD does not place a lien on member's property.

**13. Can I transfer my property while receiving LTC Medicaid?**

Transfers that occur at less than fair market value may affect LTC Medicaid eligibility.

Please reference HCA-MAD Asset Transfer NMAC.

*For more information:*

[8.200.430 NMAC](#)

[8.281.500.14 NMAC](#)

[27-2A-1 NMSA](#)

[42 U.S.C. 1396](#)



HEALTH CARE  
AUTHORITY

## ESTATE RECOVERY ASSET IDENTIFICATION

Recipient:

MERP #:

Federal law requires that the cost of long-term medical care be repaid from the estates of certain Medicaid recipients. This law is carried out through the New Mexico Estate Recovery Program. As a result, the estate of any New Mexico Medicaid recipient over age 55, who received long-term care, home and community based services through the Medicaid program is subject to recovery.

**Instructions:**

- Provide all requested information and sign at the end of this form.
- Provide a copy of the deceased member's death certificate. (No exceptions; a copy must accompany this questionnaire.) Provide copies of all additional documentation identified.
- Provide an address where information may be sent regarding this form.

**Asset Identification form and documents can be either mailed to:**

NM Estates Program  
P.O. Box 10530  
Phoenix AZ 85064

E-mail to: [nmestate@gainwelltechnologies.com](mailto:nmestate@gainwelltechnologies.com)  
Or submitted electronically at: [submissions.hms.com](http://submissions.hms.com)

If you have any questions about how to complete this form, please call toll-free 800-293-3973

| Person Completing this form:   |                |
|--|----------------|
| Name: _____  | Address: _____ |
| Telephone: _____   | _____          |
| <p>Please Check all that apply:</p> <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;"> <input type="checkbox"/> Personal Representative                 </div> <div style="text-align: center;"> <input type="checkbox"/> Attorney for Estate                 </div> </div> <div style="text-align: center; margin-top: 10px;"> <input type="checkbox"/> Other: _____                 </div> |                |



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Have there been or are there any anticipated Court filing against, on behalf of or in regard to the estate?

Yes  No

If **YES** provide: Case or File number: \_\_\_\_\_ Date Filed: \_\_\_\_\_

County Court: \_\_\_\_\_

Has a petition for probate of the estate been filed?  Yes  No

If **YES** provide: Case or File number: \_\_\_\_\_ Date Filed: \_\_\_\_\_

County Probate Court: \_\_\_\_\_

If **NO**, do you anticipate a petition for probate being filed?  Yes  No

### Decedents Information:

Name:

Marital Status:  Married  Divorced  Never Married

If married is the decedents spouse deceased?  Yes  No

Provide his/her information below and **provide proof of marriage.**

Spouse Name:  
Date of Birth:  
Social Security Number:

Spouse Name:

### Decedents Asset Information:

List all assets of the applicant/recipient and how the ownership of the asset is titled. Some examples of assets are: house(s) and land, vehicle(s), bank account(s), and other investments.

| PROPERTY TYPE    | ADDRESS    | CITY/STATE       | ESTIMATED VALUE |
|------------------|------------|------------------|-----------------|
| 1.               |            |                  |                 |
| 2.               |            |                  |                 |
| VEHICLES         | CITY/STATE | VIN/PLATE NUMBER | ESTIMATED VALUE |
| 1.               |            |                  |                 |
| 2.               |            |                  |                 |
| ACCOUNT TYPE     | BANK NAME  | ACCOUNT NUMBER   | CURRENT BALANCE |
| 1.               |            |                  |                 |
| 2.               |            |                  |                 |
| OTHER (DESCRIBE) | LOCATION   |                  | ESTIMATED VALUE |
| 1.               |            |                  |                 |
| 2.               |            |                  |                 |

For any additional Assets please use a separate piece of paper.

I certify that the information I have provided is true and complete to the best of my knowledge.

Signature of Authorized Representative:

Date:



HEALTH CARE  
AUTHORITY

## RECUPERACIÓN DE PATRIMONIO IDENTIFICACIÓN DE ACTIVOS

La ley federal requiere que el costo de la atención médica a largo plazo se pagaría con los bienes de alguno de los beneficiarios de Medicaid. Esta ley se lleva a cabo a través del Programa de Recuperación de New México. Como resultado, el estado de cualquier New México Medicaid receptor mayor de 55 años, quien recibió la atención a largo plazo, el hogar y los servicios basados en la comunidad a través del programa Medicaid está sujeta a la recuperación.

### Instrucciones:

- Proporcionar toda la información solicitada y firmar al final de este formulario.
- Proporcionar una copia del certificado de defunción del miembro fallecido. (Sin excepciones, una copia debe acompañar a este cuestionario.) Proporcione copias de toda la documentación adicional identificada.
- Proporcionar una dirección donde se puede enviar información acerca de este formulario.

**Esta forma y los documentos pueden ser enviados por correo a cualquiera de las tres:**

NM Estates Program  
P.O. Box 10530  
Phoenix AZ 85064

Correo electrónico a: [nmestate@gainwelltechnologies.com](mailto:nmestate@gainwelltechnologies.com)  
O puede electrónicamente someterlo a: [submissions.hms.com](mailto:submissions.hms.com)

Si usted tiene alguna pregunta sobre como completar este formulario, por favor llame al 800-293-3973

### Persona que Completa este Formulario:

|   |  |
|---|--|
| Nombre: _____   | Dirección: _____   |
| Teléfono: _____   | _____  |
| Por favor, marque todas las que correspondan:   | <input type="checkbox"/> Representante Personal <input type="checkbox"/> Abogado de Bienes<br><input type="checkbox"/> Otro: _____ |
| ¿Ha habido (o anticipa usted) las demandas presentadas en nombre de los bienes? <input type="checkbox"/> Si <input type="checkbox"/> No |  |
| En caso afirmativo proporcionar:  | Caso o numero de archivos: _____      Fecha de Radicación: _____   |

Corte del Condado: \_\_\_\_\_

¿Ha presentado una solicitud de legalización de la propiedad?  Si  No

En caso afirmativo proporcionar:      Caso o numero de      Fecha de  
archivos: \_\_\_\_\_      Radicación: \_\_\_\_\_

Corte del Condado de Sucesiones: \_\_\_\_\_

En caso negativo, ¿se anticipa una presentación de petición de legalización?  Si  No

### Información del Difunto:

Nombre:

Estado Civil:       Casado       Divorciado       Nunca se ha casado

¿Si está casado es el cónyuge del difunto fallecido?  Si  No

Proporcione su información abajo y proporcione la **prueba del matrimonio**.

Nombre del cónyuge:  
Fecha de Nacimiento:  
Número de Seguro Social:

### Difunto Información de Activos:

Lista todos los activos del solicitante/beneficiario y como la propiedad del activo se titula. Algunos ejemplos de activos son: casa(s) y de la tierra, vehiculo(s), cuenta bancaria(s), y otras inversiones.

| TIPO DE PROPIEDAD | DIRECCIÓN        | CIUDAD/ESTADO    | VALOR ESTIMADO |
|-------------------|------------------|------------------|----------------|
| 1.                |                  |                  |                |
| 2.                |                  |                  |                |
| VEHÍCULOS         | CIUDAD/ESTADO    | VIN/MATRÍCULA    | VALOR ESTIMADO |
| 1.                |                  |                  |                |
| 2.                |                  |                  |                |
| TIPO DE CUENTA    | NOMBRE DEL BANCO | NÚMERO DE CUENTA | BALANCE ACTUAL |
| 1.                |                  |                  |                |
| 2.                |                  |                  |                |
| OTRO (DESCRIBIR)  | UBICACIÓN        |                  | VALOR ESTIMADO |
| 1.                |                  |                  |                |
| 2.                |                  |                  |                |

Para cualquier Activos adicionales por favor use una hoja de papel

Certifico que la información que he proporcionado es verdadera y completa a mi mejor entender.

|                                     |        |
|-------------------------------------|--------|
| Firma del Representante Autorizado: | Fecha: |
|-------------------------------------|--------|

Example Letter

New Mexico Estates  
PO Box 10530  
Phoenix AZ 85064

XXXX



HEALTH CARE  
AUTHORITY



|                       |
|-----------------------|
| FOR OFFICIAL USE ONLY |
| CASE NAME             |
| MEDICAID ID NUMBER    |
| ESTATE CASE ID NUMBER |
| NOTICE SENT           |

Date

**NEW MEXICO ESTATE RECOVERY  
NOTICE OF RECOVERY**

RE: Estate of  
Medicaid ID#:  
Date of Death:

Dear :

This letter is to notify you that Health Management Systems (HMS), on behalf of the Health Care Authority (HCA) intends to seek recovery from the estate of XXXX for the amount of medical assistance paid on behalf of XXXX. HCA is the State Agency authorized to provide Medicaid services. HCA contracts with HMS to conduct its Estate Recovery Program. The claim against the estate is \$0.00 for the period Date through Date.

The Social Security Act (42 U.S.C. 1396p) and State law NMSA § 27-2A-1 et seq., require HCA to recover Medicaid expenditures paid by HCA for clients who were 55 years and older and are now deceased. The HCA claim against the estate includes payments for:

- Nursing Facility services,
- Home and Community Based services, and
- Related hospital and prescription drug services

We have enclosed a copy of the HCA Long Term Care Payment History for the client listing the expenditures subject to recovery.

## **Exceptions**

HCA may defer, waive, or reduce its claim against the estate if one of the following exceptions below exists:

- Estate Claim Statutory Exemption
- Undue Hardship Waiver
- Partial Recovery

If you believe that one of these exceptions may apply, please refer to the Application for that Exception included with this notice. You are additionally directed to inform the heirs that they may also apply for an Exception. The Application will provide further information on how to request a deferral, waiver, or reduction of the estate claim and the supporting documentation that must be provided. The Application must be received in our office within 30 days from the date of this notice.

## **Administrative Hearing Rights**

**Right to a hearing:** The Health Care Authority (HCA) must grant an opportunity for an administrative hearing.

- A. When a recipient requests an administrative hearing because he believes that HCA has taken an action erroneously.
- B. When services of a medicaid recipient are terminated, modified, reduced, suspended, or denied.

**Time limits:** A medicaid recipient has 90 days from the date of notice of action to request a fair hearing. To be considered timely, the request must be received by the HCA hearings bureau, the local Income Support Division (ISD) office, or Medical Assistance Division (MAD) no later than the close of business on the 90th day. In order to receive continuation of benefits while the hearing process goes forward, the request must be received by HCA (including the HCA hearings bureau, the local ISD office, or the medical assistance division) no later than the close of business on the 13th day. Hearings are conducted and a written decision is issued by the medical assistance division director or designee to the recipient within 90 days from the date that HCA receives the hearing request.

**Contact:** Health Care Authority, Hearings Bureau  
P.O. Box 2348  
Santa Fe, NM 87504  
1-800-283-4465

## **Acknowledgement**

Please acknowledge receipt of this letter within 30 days of the date of this notice by completing the enclosed receipt form and returning it to us in the enclosed business reply envelope.

If you have any questions, please do not hesitate to call me at the toll free number listed below.

Sincerely,  
HMS Caseworker

Enclosures:

Receipt form  
HCA Long Term Care Payment History  
Applications for Estate Claim Statutory Exemption, Undue Hardship Waiver, or Partial  
Reduction  
Copy of the Court Claim Against the Estate (*if filed*)

# I. Application For Statutory Exemption

Recovery from the a recipient's estate will be made only after the death of the recipient's surviving spouse, if any, and only at a time that the recipient does not have surviving child(ren) who are less than 21 years of age or blind or who meet the social security administration's definition of disability.

HCA will defer its claim against the estate when the HCA client is survived by a surviving spouse, a surviving child under age 21, or a surviving child of any age who is blind or disabled and receives SSI or SSA disability benefits. If the HCA client is survived by any of these individuals, check the appropriate boxes below and attach supporting documentation.

**I am attaching documentation which verifies that the HCA client is survived by one of the following individuals (please check all that apply):**

- Spouse; Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_
- Child under the age of 21; or
- Child of any age who is blind or disabled and receives Social Security Administration (SSA) disability benefits or Supplemental Security Income (SSI) disability benefits.

## AFFIRMATION

- I have attached, or have already provided to HMS a copy of the marriage license and a copy of the HCA client's death certificate.
- I have attached, or have already provided to HMS a birth certificate or other legal document that verifies the child's age and the child's relationship to the HCA client.
- I have attached, or have already provided to HMS a birth certificate or other legal document that verifies the child's relationship to the HCA client, and a copy of the child's SSA/SSI disability benefit award letter from the Social Security Administration which verifies the child receives SSA or SSI disability benefits.

By signing below I certify that the information I have provided for an Estate Claim Statutory Exemption is true and correct.

\_\_\_\_\_  
Signature of Authorized Representative

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

\_\_\_\_\_

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address (Street, City, State, Zip Code)



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## II. Application for Undue Hardship

**HCA or its designee may waive recovery because recovery would work an undue hardship on the heirs: The following are deemed to be causes for hardship:**

1. Without the receipt of the proceeds of the estate, the heir(s) would become eligible for a needs-based assistance program (such as Medicaid or temporary assistance to needy families (TANF))  YES  NO
2. Without the receipt of the proceeds of the estate, the heir(s) would be put at risk of serious deprivation.  YES  NO
3. Heir(s) would be able to discontinue reliance on a needs-based assistance program (such as Medicaid or temporary assistance to needy families (TANF) if he/she received the inheritance from the estate.  YES  NO
4. The assets subject to recovery are the sole income source for the heir(s).  YES  NO
5. The homestead is worth 50 percent or less than the average (median) price of a home in the county where the home is located based on census data compared to the property tax value of the home.  YES  NO

**If you answered YES to any of these questions, you must provide all of the documents listed below to verify your responses.**

- I have enclosed a copy of the County Assessor's Statement or an official document from the New Mexico State Department of Revenue that verifies the HCA client's real property is residential property.
- I have enclosed a copy of my most recent Federal income tax return and verification of all gross income received by my household.

**You may qualify for an Undue Hardship based on your responses to Questions 6 through 9 below.**

6. Do you currently reside at the HCA client's residence?  YES  NO
7. Did you reside at the HCA client's residence at the time of the client's death?  YES  NO
8. Is the HCA client's residence also your primary residence for the 12 months immediately preceding the HCA client's death?  YES  NO
9. Do you own a residence?  YES  NO

**If you answered YES to Questions 6 through 8, and NO to Question 9, you must provide all of the documentation listed below to verify your responses**

- I have attached verification which establishes that I resided continuously at the residential property for the 12 month period immediately preceding the HCA client's death
- I have attached verification which establishes that I resided at the residential property at the time of the HCA client's death, and
- I have attached verification which establishes that I currently reside at the residential property. Acceptable verification includes utility or other statements, pay stubs, vehicle registration, etc.



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**Personal Property Estate Assets Only:**

- 1. Does the estate contain only Personal Property assets and no residence?  YES  NO
- 2. Does your household's gross annual income, which includes new sources of income, exceed the Federal Annual Income Poverty Guidelines?  YES  NO
- 3. Do you own a home, land, or other real property?  YES  NO

**If you answered YES to Question 1, and NO to Questions 2 and 3, you must provide all of the documentation listed below to support your responses.**

- I have attached a copy of my most recent Federal income tax return and verification of my household's gross annual income; including new sources of income my household expects to receive.

**AFFIRMATION**

- I have attached, or have already provided to HMS a copy of the Inventory of the HCA client's estate.
- I have attached, or already provided to HMS a copy of the HCA client's last will to verify that I am an heir to the HCA client's estate.
- The HCA client died intestate (without a Will). I have attached legal documents to verify that I am a descendant to the HCA client. If I am not a descendant to the HCA client, I have attached an "Affidavit of Heirship" which verifies that I am a legal heir to the HCA client's estate.

By signing below, I certify that the information I have provided for an Undue Hardship Waiver of Estate Claim is true and correct.

\_\_\_\_\_  
Signature of Authorized Representative

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

\_\_\_\_\_

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address (Street, City, State, Zip Code)

### III. Application for Partial Reduction

If you wish to apply for consideration of a Partial Reduction of the Estate Claim, please answer all of the following questions and provide supporting documentation to verify your responses.

1. Will enforcement of the full amount of the HCA claim against the HCA client's estate create a financial hardship to you and your household?  YES  NO

If **YES**, please explain how enforcement of the full amount of the HCA claim will cause you and your household a financial hardship, and provide documentation that supports how your household will experience a financial hardship if the full amount of the HCA claim is enforced. \_\_\_\_\_

\_\_\_\_\_

2. Will enforcement of the HCA claim against the HCA client's estate create a medical hardship to you and your household?  YES  NO

If **YES**, please explain how enforcement of the full amount of the HCA claim will cause you or your household a medical hardship and provide documentation that supports how your household will experience a medical hardship if the full amount of the HCA claim is enforced. \_\_\_\_\_

\_\_\_\_\_

3. What is the total number of persons living in your household (include yourself)?

\_\_\_\_\_

4. Does your household's gross annual income exceed the Federal Income Poverty Guidelines for your household size?  YES  NO

5. What is the total fair market value of your household's real and personal property assets, including any encumbrances? \$ \_\_\_\_\_. Attach verification which verifies the fair market value of all sources of real and personal property assets that are owned by you and your household.

6. Are there any other creditors who have a claim against the HCA client's estate?  YES  NO

If **YES**, list the names of the creditor(s) and the amount of the creditor's claim. \_\_\_\_\_

\_\_\_\_\_

7. Have any of the creditors that you listed in Question 6 above, foreclosed on the real or personal property in the HCA client's estate?  YES  NO

8. Are there any other factors you would like HCA to take into consideration? If so, please provide an explanation of the factors you would like considered and attach supporting documentation. \_\_\_\_\_

\_\_\_\_\_



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**AFFIRMATION**

- I have attached, or have already provided to HMS a copy of the Inventory of the HCA client's estate.
- I have attached, or already provided to HMS a copy of the HCA client's last will to verify that I am an heir to the HCA client's estate.
- The HCA client died intestate (without a Will). I have attached legal documents to verify that I am a descendant to the HCA client. If I am not a descendant to the HCA client, I have attached an "Affidavit of Heirship" which verifies that I am a legal heir to the HCA client's estate.

By signing below I certify that the information I have provided for a Partial Recovery of the Estate Claim is true and correct.

|  |                             |
|--|-----------------------------|
| _____<br>Signature of Authorized Representative  | _____/_____/_____<br>(Date) |
| _____<br><br>_____                               | _____<br>Telephone Number   |
| _____<br>Address (Street, City, State, Zip Code) |                             |