

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 120 ELIGIBILITY POLICY - CASE ADMINISTRATION

8.106.120.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.120.1 NMAC - Rp, 8.106.120.1 NMAC, 7/1/2024]

8.106.120.2 SCOPE: The rule applies to the general public.
[8.106.120.2 NMAC - Rp, 8.106.120.2 NMAC, 7/1/2024]

8.106.120.3 STATUTORY AUTHORITY: Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.120.3 NMAC - Rp, 8.106.120.3 NMAC, 7/1/2024]

8.106.120.4 DURATION: Permanent.
[8.106.120.4 NMAC - Rp, 8.106.120.4 NMAC, 7/1/2024]

8.106.120.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.106.120.5 NMAC - Rp, 8.106.120.5 NMAC, 7/1/2024]

8.106.120.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally-matched financial assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.120.6 NMAC - Rp, 8.106.120.6 NMAC, 7/1/2024]

8.106.120.7 DEFINITIONS: [RESERVED]

8.106.120.8 REPORTING REQUIREMENTS:

A. HCA responsibilities: The HCA shall inform the benefit group of its responsibility to report changes. Appropriate action shall be taken to determine if the change affects eligibility or benefit amount. The date the change is reported and the action taken shall be documented. In some circumstances the HCA shall request clarification during a certification period whenever information becomes known to the HCA indicating a possible change in a benefit group's circumstances that may affect eligibility or benefit amount. Circumstances that may require follow-up review include, but are not limited to:

- (1) compliance with a contingency requirement by an adult with a determined disability;
- (2) school attendance of children age six or older who are benefit group members;
- (3) any other anticipated or reported change in circumstances that may affect eligibility or benefit amount during a certification period;
- (4) the need for a disability review to determine if disability still exists.

B. Benefit group responsibilities at application: A benefit group must report all changes affecting eligibility and benefit amount that may have occurred since the date the application was filed and before the date of the interview. Changes occurring after the interview, but before the date of the approval notice, must be reported by the benefit group within 10 days of the date the change becomes known to the benefit group.

C. Set and variable term GA: Within 10 days of the date the change becomes known to the benefit group, a recipient of GA, shall be required to report the following changes:

- (1) a benefit group's income in excess of eighty-five percent of federal poverty guidelines for size of the benefit group;
- (2) a benefit group, or the HCA receives evidence that the eligible recipient has started

receipt of SSI, OASDI or both;

(3) that the benefit group has moved from the state or intends to move from the state on a specific date;

(4) a benefit group requests closure; or

(5) the HCA receives documented evidence that the head of benefit group has died.

D. Responsibility to report: A benefit group must report changes within 10 days of the date a change becomes known to the benefit group.

(1) A financial change becomes known to the benefit group when the benefit group receives the first payment attributed to an income or resource change, or when the first payment is made for an allowable expense.

(2) A nonfinancial change, including but not limited to a change in benefit group composition or a change in address, becomes known to the benefit group on the date the change takes place.

(3) A change reported by the benefit group on the date the report of change is received by the local county office or, if mailed, the date of the postmark on the benefit group's report, plus three mailing days.

(4) In the absence of a written report, a 13-day notice of adverse action is required if the change will result in a reduction or termination of benefits.

E. Effective date of change: Changes to eligibility based on reported changes shall be effective pursuant to regulation at 8.106.630.9 NMAC.

[8.106.120.8 NMAC - Rp, 8.106.120.8 NMAC, 7/1/2024]

8.106.120.9 CERTIFICATION PERIODS:

A. Set term GA: The certification period shall be for a set length of time dependent upon conditions, beginning from the month of approval and is not subject to review. The certification period shall be set for the length of the disability established by medical documentation, not to exceed eight months.

B. Variable term GA: The certification period shall be set for a length of time, not to exceed 12 months, beginning from the month of approval and is subject to review.

(1) Dependent child in the benefit group: The certification period will be set for up to six months.

(2) ARSCH: The certification period will be set for 12 months.

(3) Disability: The certification period will be set for a length of time not to exceed 12 months, subject to expected duration of disability based on medical documentation.

[8.106.120.9 NMAC - Rp, 8.106.120.9 NMAC, 7/1/2024]

8.106.120.10 ELIGIBILITY RECERTIFICATION:

A. Recertification of eligibility: The HCA shall provide notice of recertification 45 days prior to the end of the certification and make a prospective determination of eligibility beginning the month following the month the certification period expires. The recertification shall consist of a determination of eligibility for an additional period of time, redetermination of the amount of cash assistance payment and a complete review of all conditions of eligibility as indicated below.

(1) Financial eligibility: Current financial eligibility must be reviewed at the end of the certification period for the specific program to determine continued eligibility for a new period of time.

(2) Disability: A disability review may or may not be required at the end of the certification period.

(3) Child support enforcement: The HCA shall ensure that all pertinent information regarding the noncustodial parent(s) of any dependent child in the benefit group, including but not limited to the current address, social security number and work place of the noncustodial parent is updated.

(4) Other programs: The HCA shall provide information about other assistance programs.

(5) Review of record: The HCA shall review the documentation contained in the record for completeness. If the record does not contain satisfactory evidence, additional verification shall be obtained.

B. Interview: A face-to-face interview shall take place at the end of the certification period, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. The county director may waive the face-to-face interview on a case-by-case basis for hardship reasons found at 8.106.110.11 NMAC. During the interview the HCA shall review with the recipient the possible changes in circumstances that must be reported and may affect the client's eligibility or benefit amount.

C. Exchange of information with the social security administration: During the review process, the caseworker may obtain information relevant to the eligibility of a family member who is an SSI recipient. If there is

a clear indication that a SSI recipient's countable income exceeds the maximum allowable under the SSI program, that information shall be reported to the SSA district office. SSA shall also be notified when it appears that the resources of an SSI recipient exceed SSI program standards.
[8.106.120.10 NMAC - Rp, 8.106.120.10 NMAC, 7/1/2024]

8.106.120.11 DISABILITY RECERTIFICATION:

A. The disability review process requires a recertification of an individual's impairment and whether an individual's impairment prevents gainful employment within an individual's capacity. A review of disability may occur simultaneously with recertification for eligibility or occur within the certification period.

B. The review shall include, but may not be limited to:

- (1) whether a recipient's disability must be reevaluated;
- (2) the next review date for reevaluation;
- (3) whether there is a need for current, updated medical reports to update the medical condition;
- (4) whether there are any changes in work-related factors;
- (5) whether a disability still exists;
- (6) whether the client has satisfactorily complied with contingency requirements and if not if good cause applies as outlined at 8.106.410.13 NMAC.

[8.106.120.11 NMAC - Rp, 8.106.120.11 NMAC, 7/1/2024]

8.106.120.12 RECERTIFICATION TIME STANDARDS:

A. GA benefits shall not continue beyond the certification period if eligibility requirements in Section 10 above have not been met; regardless of disability review.

B. Reapplication:

- (1) Timely reapplication: Applications submitted before the 15th of the expiration month will be considered timely.
- (2) Untimely reapplication: An application received after the 15th but before the end of a benefit group's certification period expires has lost its right to interrupted benefits.
 - (a) If the benefit group is determined eligible, without regard to disability, the benefit group is entitled to ongoing benefits that are not prorated.
 - (b) Initial month verification standards will be used for all applications received more than one calendar month after the certification period expires or the case has been closed for any reason.
- (3) Late applications: An application that is submitted to ISD within 30 days after the certification period has expired or the case has been closed for any reason can be accepted and recertification standards outlined in 8.102.120.9 NMAC will be followed. If approved, the benefits will be prorated from the date of approval. Any applications received more than 30 days after the certification period expires or closes for any reason will follow the initial month verification standards.

C. Verification: A benefit group that has reapplied timely, completed an interview and provided required verification, specific to eligibility, will be given 10 days to provide the verification or until the certification period expires, whichever is longer. If the certification period expires before the 10-day deadline for submitting the required verification, the benefit group will be entitled to a full month's benefits, if eligible, within five days after verification is submitted.

D. Agency failure to act: A benefit group that has made a timely application for recertification, but due to agency error, is not determined eligible in sufficient time to provide for issuance by the benefit group's normal issuance date in the following month, will be entitled to restoration of lost benefits.
[8.106.120.12 NMAC - Rp, 8.106.120.12 NMAC, 7/1/2024]

HISTORY OF 8.106.120 NMAC:

History of Repealed Material:

8.106.120 NMAC, Eligibility Policy - Case Administration, filed 06/17/2004 - Repealed 12/01/2009.

8.106.120 NMAC - Eligibility Policy - Case Administration (filed 11/17/2009) - Repealed effective 7/1/2024.

Other: 8.106.120 NMAC - Eligibility Policy - Case Administration (filed 11/17/2009) Replaced by 8.106.120 NMAC - Eligibility Policy - Case Administration, effective 7/1/2024.