endangers the safety of a client as well as handling the client with more force than is necessary also constitute physical abuse.

T. "Physical restraint" means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body other than physical guidance and prompting techniques of brief duration.

U. "Protective devices" means helmets, safety goggles or glasses, guards, mitts, gloves, pads and other common safety devices that are normally used or recommended for use by persons without disabilities while engaged in a sport, occupation, or during transportation.

V. "Service provider" means a private entity that has entered into a contract or provider agreement with the authority or that is certified by the authority for the purpose of providing supports and services to individuals with developmental disabilities. When the context requires, the service provider means the executive director or administrator having authority to bind the service provider. Service provider does not include facilities operated by the authority.

W. "Sexual abuse" means sexual activity between a client and staff, nonconsensual sexual activity or contact with others without regard to injury, and sexual exploitation. Sexual activity includes, but is not limited to kissing, hugging, stroking or fondling with sexual intent; oral sex or sexual intercourse; and request or suggestion or encouragement by staff for performance of sex with the employee or another. Sexual intent is to be determined by an examination of all the circumstances related to the incident. Sexual exploitation includes sexual exploitation as defined in the Abuse and Neglect Act, Subsection F of Section 32A-4-2 NMSA 1978 and allowing, permitting or encouraging obscene or pornographic filming or photographing of an adult client without their consent for commercial or noncommercial purposes.

[8.371.3.7 NMAC - N, 7/1/2024]

8.371.3.8 REGULATION DOES NOT CREATE AN ENTITLEMENT TO SERVICES: Nothing in this regulation shall provide an entitlement to programs, supports, services or benefits that does not otherwise exist pursuant to other law or regulation.

[8.371.3.8 NMAC - N, 7/1/2024]

8.371.3.9 REGULATION DOES NOT CREATE A CAUSE OF ACTION: Any rights or remedies provided pursuant to this regulation that do not otherwise exist pursuant to other law or regulation are enforceable only through the client complaint procedure and are not enforceable in court. Nothing in this regulation shall create a right of judicial review of the administrative decision of the director or the secretary or the secretary's designee made pursuant to the client complaint procedure.

[8.371.3.9 NMAC - N, 7/1/2024]

8.371.3.10 CLIENT RIGHTS: Unless expressly modified by court order or specifically granted to a guardian or conservator, all clients have:

A. the same legal rights guaranteed to all other individuals under the United States Constitution, New Mexico State Constitution, and federal and state laws;

B. the right to be free from unlawful discrimination on the basis of race, age, religion, color, national origin, ancestry, sex, sexual preference, physical or mental handicap or medical condition;

C. the right to be free from emotional or psychological abuse, physical abuse, sexual abuse, neglect and exploitation of their personal property;

D. the right to practice the religion of their choice or to abstain from the practice of religion;

E. the right to safe working conditions, hours of labor and wages for labor consistent with the Fair Labor Standards Act and other applicable federal and state laws, and worker's compensation, except that clients receiving residential services may be required to do normal housekeeping and home maintenance chores; clients shall not be required to perform labor involving the essential operation of the service provider, including the care and treatment of other clients; clients may volunteer to do labor, consistent with federal and state labor laws; if a client volunteers to do work for which the program would otherwise be required to pay non-clients, the client shall be paid a commensurate wage;

F. the right to consent to or refuse medical treatment, medical services, and other forms of habilitation services or supports, consistent with the ISP regulations and the duties of a parent, guardian or treatment guardian pursuant to the requirements of the Children's Mental Health and Developmental Disabilities Act, Section 32A-6-14 NMSA 1978 (1993 Repl.) or the Mental Health and Developmental Disabilities Act, Section 43-1-15 NMSA 1978 (1993 Repl.);

G. the right to have privacy, including both periods of privacy and places of privacy;

H. the right to communicate freely with persons of their choice in any reasonable manner and at any reasonable time they choose;

I. the right to own, use and control real property and personal possessions;

J. the right to engage in social interaction with members of either sex;

K. the right to enter into contract, including the contract to marry;

L. the right to engage in consensual sexual activity, except sexual activity defined as sexual abuse;

M. the right to procreate and to parent or not to procreate;

N. the right to manage their financial affairs, unless the client has a court appointed guardian or conservator or access to their funds is restricted by the individual service

plan; a service provider who manages the funds of a client pursuant to the client's individual service plan shall comply with applicable federal standards or regulations and the following requirements:

(1) the service provider shall have obtained informed consent and written authorization from the client or the guardian or conservator, which shall state the service provider's responsibilities;

(2) the service provider shall maintain a written record of all financial transactions involving the funds of the client and shall make the record available to the client and the guardian or conservator upon request;

(3) the service provider shall provide for the safekeeping of the funds, shall keep the funds separate from all other funds and shall be held strictly accountable for the funds and any interest;;

(4) the service provider shall return the funds to the client or guardian or conservator, including interest, upon request. Upon the death of a client, the service provider shall provide the executor or personal representative a complete accounting of all funds and property;

O. the right to participate in the political process, including the right to vote;

P. the right to have access to their records, except as expressly limited by statute, and to have confidential treatment of all information in their records, including personal and medical records; confidentiality does not preclude access to an individual's records by an individual or organization otherwise entitled under federal or state law to review records;

Q. the right to voice grievances and complaints and to recommend changes in service provider policies and services without restraint, interference, coercion, discrimination or reprisal;

R. the right to have access to available advocacy services, including consultation and assistance on the individual's concerns and training on legal rights;

S. the right to refuse to participate in medical or psychological research experimentation;

T. the right to be free from excessive use of medical restraint;

U. the right to be free from the use of chemical restraint;

V. the right to be free from the use of physical restraint except in an emergency;

W. the right to be free from limitations on freedom of movement except in an emergency;

X. the right to be free from the use of mechanical restraint; and

Y. the right to be free from the use of aversive procedures.

[8.371.3.10 NMAC - N, 7/1/2024]

8.371.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:

A. A service provider shall not restrict or limit a client's rights except:

(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or

(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens their physical safety; or

(3) as provided for in Subsection N of 8.371.3.10 NMAC.

B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other authority regulation or policy.

C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights.

[8.371.3.11 NMAC - N, 7/1/2024]

8.371.3.12 RETALIATION FOR INITIATION OF COMPLAINT PROCEDURE PROHIBITED: A client has the right to present or make known a complaint without restraint, interference or coercion. A service provider shall not retaliate or discriminate against a client, staff person or other person who complains to the service provider or initiates a complaint procedure.

[8.371.3.12 NMAC - N, 7/1/2024]

8.371.3.13 CLIENT COMPLAINT PROCEDURE AVAILABLE: A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10. The authority will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure.

[8.371.3.13 NMAC - N, 7/1/2024]

HISTORY OF 8.371.3 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 371 DEVELOPMENTAL DISABILITIES
PART 4 CLIENT COMPLAINT PROCEDURES

8.371.4.1 ISSUING AGENCY: New Mexico Health Care Authority, Developmental Disabilities

Division.
[8.371.4.1 NMAC - N, 7/1/2024]

8.371.4.2 SCOPE:
A. This regulation applies only to clients and service providers as defined below.
B. Except as described in Section VII (A), this regulation is not available to resolve disputes concerning the content of or the substantial failure to implement a community individual service plan. Any dispute concerning the content of a plan or any claim alleging substantial failure to implement a plan must be raised in the dispute resolution process, if available. This regulation is not available to review any action by a service provider or the authority to suspend, terminate or reduce medicaid covered services if a fair hearing procedure is available pursuant to federal law.
C. Nothing in this regulation alters or modifies the duty of any person having reason to believe that a person is being abused, neglected, or exploited to report that information as required by the Adult Protective Services Act, Section 27-7-30 NMSA 1978 (1992 Repl.) and the Abuse and Neglect Act, Section 32A-4-3 NMSA 1978 (1993 Repl.)
[8.371.4.2 NMAC - N, 7/1/2024]

8.371.4.3 STATUTORY AUTHORITY: Subsection E of Section 9-8-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.
[8.371.4.3 NMAC - N, 7/1/2024]

8.371.4.4 DURATION: Permanent.
[8.371.4.4 NMAC - N, 7/1/2024]

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

8.371.4.6 OBJECTIVE: The purpose of this regulation is to promote the health, safety and welfare of individuals who are receiving supports and services for persons with developmental disabilities from service providers certified by or funded in whole or in part with state funds administered by the authority through contracts or agreements. This regulation provides a procedure to address client complaints and provides that the authority will enforce remedies for substantiated complaints through the service providers funding contract or provider agreements.
[8.371.4.6 NMAC - N, 7/1/2024]

8.371.4.7 DEFINITIONS:
A. "Client" means a person with developmental disabilities who is receiving supports and services for individuals with developmental disabilities by a service provider certified by or funded in whole or in part with state funds administered by the authority through contracts or agreements.
B. "Complainant" means a client or their legal guardian who files a complaint pursuant to this regulation.
C. "Days" means calendar days.
D. "Developmental disabilities" means a severe chronic disability of a person that:
(1) is attributable to a mental or physical impairment, including the result from trauma to the brain, or a combination of mental and physical impairments;
(2) is manifest before the person reaches the age 22 years;
(3) is expected to continue indefinitely;
(4) results in substantial functional limitations in three or more of the following areas of major life activity:
(a) self-care;
(b) receptive and expressive language;
(c) learning;
(d) mobility;
(e) self-direction;
(f) capacity of independent living; and
(g) economic self-sufficiency.
E. "Director" means the director, developmental disabilities division or the director's designee.
F. "Division" means the developmental disabilities division of the authority.
G. "Emergency" means a circumstance in which the health or safety of the client or another person is in immediate and serious jeopardy and must be protected immediately to stop or prevent harm.
H. "Facilities" means institutions operated by the authority.
I. "Guardian" means the parent of an individual with developmental disabilities if the client is a minor or a legal guardian appointed or recognized pursuant to the Uniform Probate Code, Section 45-5-101. et. Seq. NMSA 1978 (1993 Repl.).
J. "Office" means the office of quality assurance or a regional office within the developmental disabilities division.
K. "Plan" means the individual service plan for services, treatment or habilitation developed by the interdisciplinary team.
L. "Service provider" means a private entity that has entered into a contact or provider agreement with the authority or that is certified by the authority for the purpose of providing supports and services to individuals with developmental disabilities. When the context requires, the service provider means the executive director or administrator having authority to bind the service provider. Service provider does not include facilities operated by the authority.
[8.371.4.7 NMAC - N, 7/1/2024]

8.371.4.8 REASONS FOR ADOPTION:
A. These regulations provide a procedure to address client

complaints and provides that the authority will enforce remedies for substantiated complaints through the service providers funding contracts or provider agreements.

B. These regulations are promulgated, in part, to satisfy requirements arising form the implementation of the decision in the Jackson v. Fort Stanton, N.M. Dist. CT. NO. Civ. 87-839, including agreements reached by the parties.
[8.371.4.8 NMAC - N, 7/1/2024]

8.371.4.9 REGULATION DOES NOT CREATE AN ENTITLEMENT TO SERVICES: Nothing in this regulation shall provide and entitlement to programs, supports, services or benefits that does not otherwise exist pursuant to other law or regulation.
[8.371.4.9 NMAC - N, 7/1/2024]

8.371.4.10 REGULATION DOES NOT CREATE A CAUSE OF ACTION: Any remedies provided pursuant to this regulation that do not otherwise exist pursuant to other law or regulation are enforceable only through the complaint and appeal process provided herein and are not enforceable in court. Nothing in this regulation shall create a right of judicial review of the administrative decision of the director or the secretary or their designee made pursuant to this regulation unless such review is available pursuant to other law or regulation.
[8.371.4.10 NMAC - N, 7/1/2024]

8.371.4.11 RETALIATION FOR INITIATION OF COMPLAINT PROCEDURE PROHIBITED: A client has the right to present or make known a complaint without restraint, interference, or coercion. A service provider shall not retaliate or discriminate against a client who complains to the service provider or initiates a complaint procedure.
[8.371.4.11 NMAC - N, 7/1/2024]

8.371.4.12 COMPLAINT PROCEDURE AVAILABLE:

A. The complaint process (Section 13 of this regulation) is available to resolve complaints alleging that a service provider, its employee, or a person acting under contract with the service provider has violated rights of the client set forth in the federal or state constitutions, statutes or applicable authority regulations or policies and such violation adversely affects the client. The administrative appeal process (Section 14 of this regulation) is available, however, only as to alleged violations of rights set forth in the federal and state constitutions, statutes and authority regulations and policies designated “client’s rights.”

B. The complaint procedure shall be available to clients or their legal guardians. The client or the legal guardian has the right to a legal representative or advocate of their choice at no expense to the authority.

C. If a complaint alleges a violation of statute, regulation or ordinance that another state agency or public entity has authority to investigate and enforce, the division may refer the complaint to that entity unless the client objects to the referral , except that the division shall report the violation when there is a statutory requirement to report. The division may decline to investigate the complaint.

D. The complaint procedure is not available to the service provider to review the final decision of the authority. The service provider may seek redress for any adverse action if provided by the terms of the service provider’s contract or provider agreement.

E. The client may withdraw their complaint at any time. If the complainant is not the client, the division shall not continue the complaint procedure under this regulation if the client objects. The division may pursue its own investigation and take corrective action as appropriate.

F. The complainant and the service provider may settle a complaint by mutual agreement unless the client objects. However, the complainant and the service provider may not modify a finding substantiating the complaint.
[8.371.4.12 NMAC - N, 7/1/2024]

8.371.4.13 COMPLAINT PROCESS:

A. Step one: Service provider review:

(1) Each service provider shall have a complaint or grievance procedure that is reviewed and approved by the division. Except as provided in Paragraph (7) below, a client or a legal guardian must initiate a complaint with the service provider within 180 days of the event or occurrence that is the subject of the complaint and in the manner set forth in the service provider’s complaint or grievance procedure.

(2) The service provider’s complaint or grievance procedure shall provide, at a minimum, that:

(a) the client is notified of the service provider’s complaint or grievance procedure;

(b) a complaint may be made orally or in writing;

(c) the service provider shall meet with the complainant if a complaint is made; if the complainant is not the client, the client shall be notified of the meeting and allowed to attend;

(d) the complainant and the client may have a representative(s) of their choice present at the meeting;

(e) the complaint will be decided by an impartial person who is not involved in the incident complained of but who may be an employee of the service provider;

(f) the complainant and their representative, if any, will receive a written response within 15 days of the complaint;

(g) the complainant has a right to file a complaint with the authority if the

complainant is not satisfied with the service provider's response; and

(h) the service provider will assist the client in filing a complaint with the division upon request.

(3) The employees or staff of the service provider shall have the responsibility to initiate a complaint on behalf of the client whenever they have reason to believe that a violation of the client's rights may have occurred.

(4) The service provider shall issue a brief written response to the client and the guardian stating the nature of the complaint and the result(s) requested by the complainant, the disputed facts, if any, the undisputed facts, if any, the resolution of the complaint of the attempts made to resolve the complaint.

(5) The service provider shall respond to the complaint in writing within 15 days of the initial complaint. The time line may be extended by mutual agreement of the complainant and the service provider. The service provider shall maintain a copy of each written response in the client's record and in a central file that is available to the authority. If the complaint alleges abuse or neglect, the service provider shall, in addition to any other requirements, provide a copy of the response to child protective services or adult protective services. If the complainant alleges abuse or neglect or if the complaint involves a dangerous condition or a risk to the client's health or safety, the service provider shall provide a copy of the written response to the office.

(6) The failure of the service provider to issue a response to a client's complaint in writing shall be a separate and independent ground for filing a complaint with the division.

(7) If a complainant alleges abuse or neglect, or if the complaint involves a dangerous condition, or a risk to the client's health or safety, the complaint may be make with the division's office pursuant to step two without initiating a complaint with the service provider.

B. Step two. Quality assurance review: Expedited investigation: In addition to the investigation and review procedures and described herein, if the office has reason to believe that the health or safety of the client is in jeopardy, the division shall, in cooperation with other agencies as necessary, take steps to ensure that the client is safe while the complaint is under investigation and shall expedite the investigation and issue preliminary findings within 10 days of receipt of the complaint. If the complainant alleges abuse or neglect or the office has reason to believe that abuse or neglect has occurred or is occurring, the office shall make an immediate referral to child protective services of adult protective services for investigation.

(1) If the complaint is not resolved, a complaint may be filed with the division's designated office. The complaint must be made orally or in writing within 20 days from the date of the written response of the service provider, unless the service provider has failed to respond in writing or the complainant is filing the initial complaint with the office as provided in Paragraph (7) of Subsection A of 8.371.4.13 NMAC.

(2) The complaint shall be a brief statement of the act(s) that is the basis of the alleged violation. The complaint may be made orally or in writing. The complainant may provide the office a copy of the service provider's written response.

(3) If the office has reason to believe that abuse or neglect has occurred or is occurring, the Office shall make an immediate referral to child protective services (CPS) or adult protective services (APS) so that they may investigate the complaint immediately. The division shall coordinate with and assist CPS and APS as necessary.

(4) The office shall examine each complaint and determine whether the complainant alleges that a service provider, its employee, or a person under contract with the provider has violated rights of the client set forth in federal or state constitutions, statutes, or applicable authority regulations or policies. If the complainant does not allege such violation of the rights of the client, or if the allegation is not against a service provider or its employee or contractor, the office shall refer the complaint to any federal, state or local governmental body or private entity with authority over the issue or subject matter unless the client objects the referral.

(5) The office shall notify the service provider of the complaint within five days of receipt of the complaint. If the complainant initiated the complaint with the service provider, the service provider shall provide the office a copy of its written response to the unresolved complaint upon request.

(6) The office shall review the complaint and determine whether an expedited investigation is necessary. If an expedited investigation is not necessary, the office will determine whether a full investigation is necessary to resolve the complaint. If the office determines that a full investigation is not necessary because the facts are not in dispute or the facts can be determined without a full investigation, the office shall issue a report within 15 days of receipt of the complaint.

(7) If the office initiates a full investigation of the complaint, the office shall contact and interview the client and their representative, if any. The office shall interview the client in person unless:

(a) the client has the capacity to be interviewed by telephone and

(b) the complaint does not involve a dangerous condition, a risk to the client's health or safety, a significant rights violation, or other serious circumstance. The complainant, the service provider, and any other persons having relevant information shall be given the opportunity to present facts and documents relevant

to the complaint.

(8) The office shall prepare a written report of the results of the investigation within 45 days of receipt of the complaint. The written report shall include a statement of the complaint, a summary of the findings of fact, a determination whether the allegation(s) is substantiated, and the reasons for the determination. If the alleged violation is substantiated, the written report shall include a recommendation of proposed action.

(9) The director shall review the office's written report. The director shall issue a written decision within 10 days of receipt of the written report, unless the director extends the time as provided below.

(a) The director shall either adopt the findings of fact or return the matter to the office with specific instructions for additional investigation and findings if he or she determines that there is insufficient information on which to base a decision. If the director returns the complaint to the office for additional investigation and findings, the director shall state the deadline for completion of the investigation and additional findings, which shall be no more that 14 days unless the director determines that circumstances require additional time.

(b) Director shall determine whether there is reason to support the complainant's allegations and determine what action, if any, should be taken. If the director reflects the findings of fact or modifies the recommendation of proposed action, the director shall state the reasons for their decision.

(10) The written decision of the division director is final unless the complainant requests an administrative hearing as provided in section of this regulation.

[8.371.4.13 NMAC - N, 7/1/2024]

8.371.4.14 ADMINISTRATIVE APPEAL PROCESS: The administrative appeal process is available only to review the decision of the division director as to alleged violations by the service provider, its employees, or persons under contract with the service provider of rights set forth in the federal or state constitutions, statutes, or authority regulations or policies designated "client's rights." The administrative hearing is intended to be accomplished without the involvement of legal counsel, but the complainant and the service provider may be represented by legal counsel of their choosing at their own expense.

A. Step one: Administrative hearing:

(1) Request for hearing:

(a) If the complainant is not satisfied with the decision of the director, the complainant may request an evidentiary hearing before and impartial hearing officer. The request must be in writing, must be filed with the director, and must be mailed within 20 days from receipt of the director's decision.

(b) The appeal shall be a brief statement of the acts that are the basis of the alleged violation of rights.

(2) Assignment of hearing officer:

(a) The director shall assign a hearing officer within 10 days of receipt of the request for hearing.

(b) If any person who may appear at the hearing, as described in Paragraph (3) of Subsection B of 8.371.4.14 NMAC, has reason to believe that the hearing officer cannot render an impartial decision, the person shall notify the director in writing stating the objection and the reason(s) therefor within five days of the date of the notice of the assignment. If the director determines that there is a good cause, the director shall assign another hearing officer within 10 days of receipt of the objection.

(3) Notice of hearing:

(a) The hearing officer shall conduct the hearing within 15 days of assignment as hearing officer. The hearing officer may grant a continuance not to exceed 15 days for good cause shown.

(b) The hearing officer shall notify the complainant and the service provider (s) of the date, time and place of the hearing at least five days prior to the hearing. If feasible, the hearing shall be held in the city or town where the client resides or at a location convenient to the client.

(c) The service provider may decline to appear at the hearing and the hearing shall proceed. The complainant and the service provider may settle the complaint by mutual agreement at any time prior to the hearing unless the client objects. The complainant shall notify the hearing officer of the settlement by withdrawing the complaint in writing prior to the hearing. The hearing officer shall notify the division director that the complainant has withdrawn the complaint.

(4) Conduct of hearing:

(a) The complainant has the burden to show by a preponderance of the evidence that:

(i) the act (s) complained occurred;

(ii) the act (s) constitutes a violation by the service provider, employee or a person under contract with the service provider, of rights of the client set forth in the federal or state constitution, statutes, or authority regulations or policies designated "client's rights"; and

(iii) the client is adversely affected.

(b) The complainant and the service provider (s) have the right to call witnesses on their behalf, question witnesses called by others, and present other evidence relevant to the complaint.

(c) The hearing officer shall admit all relevant evidence that is reasonably likely to assist him or her in making a fully informed, fair decision. The

hearing officer may exclude irrelevant or repetitious evidence. Conformity to rules of evidence is not required. The hearing officer's rulings on evidence are final.

(5) Recommended decision of the hearing officer:

(a) The hearing officer shall render a recommended decision to the secretary of the authority or the secretary's designee in writing within 10 days of the hearing.

(b) The recommended decision shall include:

(i) a statement of uncontested facts and finding of fact on contested issues; and

(ii) a recommendation dismissing the complaint as not supported by a preponderance of the evidence; or

(iii) a finding substantiating the complaint and a recommendation either adopting the authority's relief or remedy or proposing individual relief or remedy.

B. Step two: Decision:

(1) The secretary or the secretary's designee may adopt the recommendation of the hearing officer or may reverse or modify the recommendation of the hearing officer. If the secretary or the designee modifies or reverses the recommendation of the hearing officer, they shall state the reasons for the decision.

(2) The secretary or their designee shall notify the persons described in Paragraph (3) of Subsection A of 8.371.4.14 NMAC of the decision in writing within 15 days of receipt of the recommendations of the hearing officer.

(3) The decision of the secretary or the secretary's designee is final and is not subject to judicial review.

[8.371.4.14 NMAC - N, 7/1/2024]

8.371.4.15 SANCTIONS, CORRECTIVE ACTION OR RELIEF:

A. Sanction, corrective action or other relief for substantiation of a complaint may include a directive prohibiting any future violation, a corrective action plan that shall be implemented as a condition for the continuation of the service provider's contract or provider agreement and enforceable under terms of the contract or provider agreement, reimbursement or repayment by the service provider of a client's funds, recoupment by the authority of a client's funds on behalf of the client, a requirement that the service provider take corrective or disciplinary action against an employee, or any other affirmative relief that is fair and just. Sanctions imposed under this regulation shall not include revocation or suspension of a license, denial of a license application, a monetary penalty, fine, compensatory damages (except reimbursement of client funds), or consequential or punitive damages except as may be specifically provided in the agreement between the service provider and the authority.

B. In imposing sanctions, corrective action or other relief, the office, director or the secretary may consider prior substantiated complaints involving the service provider, if any, data from child protective services or adult protective services abuse or neglect reports, performance audit reviews, and the responsiveness of the service provider to prior remedial action imposed by the division or other authority.

C. If the complainant's allegation is substantiated and sanction or corrective action is imposed or other relief granted, the division may require that the service provider prepare and submit documents to the division or allow access to records necessary to demonstrate the service provider is in compliance with the provisions of the sanction, corrective action or other relief.

D. If the complaint is substantiated, the notice of final action shall state that the division may impose additional sanctions for failure of the service providers to comply with the decision and may impose sanctions, corrective action or other relief as provided in Subsection A of 8.371.4.15 NMAC in addition to the individual remedy or relief granted.

[8.371.4.15 NMAC - N, 7/1/2024]

8.371.4.16 ACTION OF THE DIVISION NOT EXCLUSIVE OF OTHER ACTION: The division shall cooperate with the health care authority licensing and certification bureau, the long term care ombudsman, the children, youth and families department, the department of labor, and medicaid fraud unit, as appropriate, regarding any investigation, allegation or substantiated complaint. Any remedy imposed by the division for violation of authority policy or regulation does not preclude other sanction or corrective action by other divisions of the authority or preclude another agency or authority with jurisdiction over the subject matter from taking action arising from the same conduct, actions or omissions.

[8.371.4.16 NMAC - N, 7/1/2024]

8.371.4.17 PUBLIC DISCLOSURE OF FINAL ACTIONS:

A. The office of quality assurance will conduct its investigations in a manner that protects the clients' privacy.

B. Complaints and documents, materials, or records not otherwise exempt from public inspection shall be subject to public inspection. Requested public records containing information that is exempt and nonexempt form disclosure shall be separated or redacted by the custodian prior to inspection, and the nonexempt information shall be made available for inspection. The complaints and related documents shall not be available for public inspection until the investigation is concluded, action of the authority is final, and any time period allowed for review or administrative hearing has expired.

C. Client identifying confidential information, records pertaining to physical or mental illness or medical treatment, and

records protected form disclosure by statute or court-recognized rule are exempt from public inspection.

D. Those portions of the division's investigation file containing confidential sources, methods, and related investigation materials may be exempt from public inspection on public policy grounds if the harm to the public interest from allowing inspection outweighs the public's right to know.

E. The authority may charge reasonable fees for copying public records.

F. The division will track complaints to ensure that the complaint process operates satisfactorily, meets time lines, and achieves any program changes required of service providers. Non-confidential data from the complaint tracking process will be available to the public. If the division produces periodic statistical reports containing aggregate information about substantiated and unsubstantiated complaints, including nonpersonally identifiable information about the complaints received, type or nature of the allegations, frequency of complaints by type and by service provider, resolution of substantiated complaints, tracking of corrective action and follow-up, other investigation results, and any other data the authority deems appropriate, the statistical reports shall be subject to public inspection.

[8.371.4.17 NMAC - N, 7/1/2024]

8.371.4.18 THIS COMPLAINT PROCEDURE IS NOT AVAILABLE FOR APPLICANTS: This complaint procedure is not available to review financial eligibility determinations or denial of applications for services. Applicants for services may seek other review that may be available under law or regulations.

[8.371.4.18 NMAC - N, 7/1/2024]

HISTORY OF 8.371.4 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 371 DEVELOPMENTAL DISABILITIES
PART 5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY

8.371.5.1 ISSUING AGENCY: New Mexico Health Care Authority, Developmental Disabilities Supports Division.

[8.371.5.1 NMAC - N, 7/1/2024]

8.371.5.2 SCOPE:

A. For each individual with developmental disabilities receiving services in the community, either through state general funds or federal funding through the developmental disabilities medicaid waiver, there shall exist a single, unified individual service plan, or ISP. This ISP shall be developed by a single interdisciplinary team, or IDT, consisting of the individual, the guardian, parents, family, and representatives from all key community service provider agencies servicing to the individual, regardless of their source of funding, as well as advocates and others invited to participate by the individual.

B. These regulations shall apply to all individuals with developmental disabilities living in the community, regardless of whether their services are funded through the developmental disabilities medicaid waiver or through state general fund contracts with community providers. The following groups are *excluded* from these regulations, as their services and service delivery are addressed in other regulations:

(1) children, aged birth to three, who are recipients of services covered by the federal Individuals with Disabilities Education Act (IDEA), Part C as administered under the New Mexico family, infant and toddler program;

(2) early periodic screening, diagnosis and treatment (EPSDT) case management recipients, unless allocated to the DD waiver;

(3) medically fragile waiver recipients;

(4) state general funded recipients of only ancillary services (non-residential and non-day program services), such as respite and the various therapies;

(5) community ICF/MR group home residents, covered by federal ICF regulations, except *Jackson* class members.

[8.371.5.2 NMAC - N, 7/1/2024]

8.371.5.3 STATUTORY AUTHORITY: Subsection E Section 9-7-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.371.5.3 NMAC - N, 7/1/2024]

8.371.5.4 DURATION: Permanent.

[8.371.5.4 NMAC - N, 7/1/2024]

8.371.5.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.371.5.5 NMAC - N, 7/1/2024]

8.371.5.6 OBJECTIVE:

A. These regulations contain a process for development of an individual service plan for persons with a developmental disability. The requirements set out in these regulations apply, with some exceptions, to providers of services to persons with developmental disabilities living in the community.

B. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in *Jackson, et al. v. Fort Stanton, et al.*, N.M. Dist. Ct. No. Civ. No. 87-839. These regulations incorporate certain agreements reached by the parties, including the authority, to the *Jackson* lawsuit.

C. The purpose of this regulation is to establish a framework for planning, designing, implementing and modifying the individual service plan for an individual with developmental disabilities living in the community.
[8.371.5.6 NMAC - N, 7/1/2024]

8.371.5.7 DEFINITIONS:

A. The Interdisciplinary Team (IDT):

(1) The **"interdisciplinary team (IDT)"** is responsible for the development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP.

(2) The IDT shall consist of the following core members:

(a) **"individual":** the person with a developmental disability for whom the ISP is written;

(b) **"case manager":** the independently-funded professional responsible for service coordination to indviduals with developmental disabilities on the developmental disabilities medicaid waiver; the case manager must be external to, and independent from, the community service provider agency;

(c) **"guardian":** the court appointed guardian of an adult individual or the custodial parent(s) if the individual is a minor;

(d) **"helper":** the individual may choose a helper to assist with communication; in instances where the individual is unable to make this choice, the guardian may choose a helper, if desired; the helper may be a friend, housemate, family member, teacher, co-worker, current or former employee of an agency or facility with which the individual has had contact, foster grandparent, or any other person from the individual's circle of relatives, friends and acquaintances;

(e) **"key community service provider staff"**: "key" community service providers are providers of residential employment, day program and behavioral services specifically designed for persons with developmental disabilities; "key" provider staff participating in the IDT shall include, at a minimum:

(i) **"direct service staff"**: the provider staff member(s) directly responsible for the provision of specified services to the individual with developmental disabilities;

(ii) **"service coordinator":** the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency;

(f) **"ancillary service providers":** the service provider agencies and staff providing non-residential and non-day services, either specifically designed for individuals with developmental disabilities or generic in nature, regardless of funding source; examples of ancillary services include nutritional services, physical therapy, occupational therapy, speech therapy, respite, nursing, etc.; as well as services provided by the individual's physician and other medical personnel;

(g) **"designated healthcare coordinator"** the team member designated to coordinate medical supports and services which the individual requires to manage any chronic health conditions and to access preventative healthcare services;

(h) **"others":** unless the individual objects, other participants may include family members not already mentioned, if invited by the individual or guardian; advocates or other chosen representatives who participate in the ISP development process on the individual's behalf; representatives of generic services, who may participate in the IDT with the individual's or guardian's consent; representatives of the public school system, if the individual is of school age and attends public school; and, any others that the individual wishes to have attend the IDT meeting.

B. Content of individual service plans:

(1) **"Demographic information":** The individual's name, age, date of birth, important identification numbers (i.e., medicaid, medicare, social security numbers, level of care), address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance.

(2) **"Long-term vision":** A written statement of the individual's personal vision for the future.

(3) **"Outcomes":** Desired outcomes generated by the individual, guardian and the team. An outcome is a realistic change that can occur in the individual's life, that the individual can achieve and that leads towards the attainment of the individual's long-term vision. For example, an outcome may state that the individual obtain preferred employment or that the individual learn to drive.

(4) **"Individual preference":** The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances and interests of the individual, shall determine the life area relevance, if any, to the individual's ISP.

(5) **"Action plans":**

(a) specific action plans designed to assist the individual in achieving each identified desired outcome listed in the ISP, by the team, which include criteria for measuring progress, timelines and responsible parties on each action step.

(b)

service providers shall develop specific tasks and strategies (methods and procedures) for implementing each specified action step within timelines established by the IDT.

(6) "Assistive technology": Necessary support mechanisms, devices, and environmental modifications including the rationale for the use of assistive technology or adaptive equipment when a need has been identified, shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as nonintrusive a fashion as possible.

(7) "Availability of supports and services": Identification of potential supports and services for individuals by the IDT should be undertaken without regard to the cost of the supports and services or whether they are actually available at that time in the community.

(8) "Signature form": A signature form, containing the name, phone number and role on the IDT of all team members shall be included in the ISP. All individuals attending the annual IDT meeting shall sign the signature form to indicate their participation in the planning process. For all team members not in attendence the alternative method of their participation shall be stated on the signature line. (e.g. telephone, written report, premeeting consultation or designated representative).

(9) "Budget page": For individuals receiving services through the developmental disabilities medicaid waiver a proposed budget page developed by the case manager in consultation with the various service providers shall be included in the ISP.

[8.371.5.7 NMAC - N, 7/1/2024]

8.371.5.8 INTRODUCTION:

A. For all recipients of the developmental disabilities medicaid waiver services, this interdisciplinary team shall be chaired by the individual, if they so desire, or by the independent case manager. Services called for in the ISP shall be coordinated by the independent case manager according to the procedures described herein.

B. For all state general fund recipients, this interdisciplinary team shall be chaired by the individual, if he or she desires, or by the designated service coordinator of a community service provider agency. Services called for in the ISP shall be coordinated by the service coordinator staff of the key community service provider agency according to the procedures described herein.

C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by accreditation entities approved and adopted by the developmental disabilities supports division and the health care authority. It is the policy of the developmental disabilities support division (DDSD) that to the extent permitted by funding, each individual receive supports and services that will assist and develop independence and productivity in the community and take affirmative action to prevent regression or loss of current capabilities. Services and supports include specialized and generic services, training, education or treatment as determined by the IDT and documented in the ISP.

D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.

[8.371.5.8 NMAC - N, 7/1/2024]

8.371.5.9 GUIDING PRINCIPLES: The following principles shall provide direction and purpose in planning with individuals with developmental disabilities.

A. Principle No. 1: The individual with developmental disabilities has choices in, and ownership of, the planning process. If the individual is unable to independently communicate, the team shall use observed preferences and consultation with close friends, family members, guardians, helpers, direct service staff and advocates to guide decisions.

B. Principle No. 2: A person-centered planning process shall be used to maintain the self-esteem of the person with developmental disabilities.

C. Principle No. 3: The individual's long-term vision statement shall guide assessments, planning, plan implementation and service evaluation. The plan shall describe reasonable accommodations and supports to assist the individual in the realization of the individual's vision.

D. Principle No. 4: Planning shall focus on outcomes or results which the individual wishes to achieve.

E. Principle No. 5: The plan shall address individual strengths and capabilities in developing action plans and strategies for reaching desired outcomes.

F. Principle No. 6: Visions shall usually reflect results which can be reached within one (1) year. Action plans will delineate which activities will be completed within one year and those which will be detailed in future plans or plan modifications.

G. Principle No. 7: The team developing the action plan shall recognize and understand that behavior is a form of communication.

H. Principle No. 8: Natural supports and services normally utilized by the community at large shall be preferred over specialized services in assisting individuals to reach desired outcomes;

when specialized services are necessary they shall take place in natural settings whenever possible.

I. Principle No. 9: The planning process shall be tailored to each individual's culture, communication style, physical requirements, learning style and personal preferences.

[8.371.5.9 NMAC - N, 7/1/2024]

8.371.5.10 AVAILABILITY OF SUPPORTS, SERVICES AND FUNDS AND DDSD APPROVALS:

A. The case manager assures that identification of potential supports and services for the individual by the IDT is undertaken without regard to the cost of the supports and services or whether they are actually available at that time in the community. If needed supports and services are not available this shall be reported to the DDSD regional office by the case manager.

B. For individuals who are not *Jackson* class members, in specifying the supports and services in the ISP required to be provided, the IDT, exercising professional judgment, may take into account the availability of supports and services. If supports or services are identified in the ISP, but not required to be provided in the exercise of professional judgment taking into account the availability of services, the IDT shall promptly submit a list of these unavailable supports and services to the DDSD. The DDSD shall use these lists to identify appropriate community resource needs and develop strategies to add community supports and services for persons with developmental disabilities, subject to appropriations for this purpose.

C. For *Jackson* class members, the ISP shall include the supports and services identified by the IDT.

D. The ISP for individuals who are on the developmental disabilities medicaid waiver, including *Jackson* class members, must be reviewed and approved by the DDSD, as to the cost of the individual's ISP, and aggregate costs of ISPs, and as to compliance with medicaid regulations and DDSD standards. If the DDSD does not approve the ISP because of cost or non-compliance with DDSD standards, the ISP will be returned to the IDT with appropriate instructions to develop an ISP that meets requirements and is within the DDSD's budget parameters. The ISP for these individuals will not be implemented unless and until it is approved by the DDSD.

E. Because cost limitations are established upfront in the contracting process for persons funded solely by state general funds, the above ISP review and approval process (per Subsection D of 8.371.5.10 NMAC above) is not required. The DDSD reserves the right to conduct on-site reviews for compliance with applicable policy and regulation.

[8.371.5.10 NMAC - N, 7/1/2024]

8.371.5.11 THE INTERDISCIPLINARY TEAM:

A. The interdisciplinary team (IDT) is responsible for the development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP.

B. The IDT shall consist of the following core members:

(1) individual: the individual shall be actively encouraged to participate in all IDT meetings and the ISP development process; this participation shall include, but not be limited to, expressing a personal vision statement for the future, indicating desired outcomes that help to realize that vision, identifying action plans that will achieve those outcomes, and personally chairing the IDT meeting, if desired and when able to do so;

(2) case manager: the duties of the case manager in relation to the individual with developmental disabilities and the IDT shall include:

(a) coordinating the development, modification and implementation of the ISP in consultation with the IDT and the individual;

(b) monitoring the integration and coordination of the individual's services;

(c) serving as the IDT chairperson, or assisting the individual in chairing the IDT meeting if he or she is capable of doing so and wishes to do so;

(d) scheduling IDT meetings annually, or more often as needed, to review or modify the ISP, and encouraging optimum participation by all IDT members;

(e) monitoring supports and services being delivered as specified in the ISP as determined by the IDT;

(f) reviewing progress on chosen outcomes, and action plans and through consultation with the IDT, amending the ISP, if needed;

(g) through timely consultation with the IDT, modifying unsuccessful service programs and developing service programs for previously unaddressed but significant individual needs that may arise prior to the next scheduled ISP meeting;

(h) advocating on behalf of the individual by making recommendations and requests on behalf of the individual;

(i) ensuring objective, quantifiable data has been systematically recorded, analyzed and used to determine effectiveness of service provided in order to justify needed changes in services;

(j) coordinating and monitoring any follow-up needed as a result of reviews;

(k) serving as liaison between the IDT and the public school system, the special education division, or any other community service teams relevant to the individual served; and

(l)

assisting the community service providers in community placement or other services as needed and as specified by the IDT;

(3) the case manager ensures that the IDT identified services and supports for the individual without regard to their current availability; at the conclusion of the IDT meeting the case manager shall document unavailable services on the appropriate page of the ISP form, which is provided for this purpose, and submits this list to the DDSD, regional office;

(4) guardian: the guardian shall convey to the IDT information about the individual, historical or otherwise, which shall be useful in the development of the ISP;

(5) helper: the helper is someone who knows the individual's capabilities, interests, likes, and dislikes and who can assist the individual in communicating these with the IDT; in turn, the helper may assist the individual in understanding the ISP development process and the individual service plan that is developed;

(6) "key" community service provider staff: "key" community service providers are providers of residential, employment day program and behavioral services specifically designed for persons with developmental disabilities; "key" provider staff participating in the IDT shall include, at a minimum:

(a) direct service staff: the participation of direct service staff in the development of the individual service plan is crucial, as they are the persons who work directly with the individual within their respective domains; at least one provider staff member from each of the "key" service areas (residential, day/work-related and behavioral), who is directly involved in the provision of services to the individual in those areas, must be in attendance at all IDT meetings;

(b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows:

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;

(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;

(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;

(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;

(7) ancillary service providers: ancillary service providers shall participate in the IDT meeting and the ISP development process through written assessments, evaluations or reports to the IDT, or in person; the case manager, in consultation with the individual and the IDT, shall determine the need for personal participation at IDT meetings on the part of any ancillary service provider;

(8) designated healthcare coordinator: the team member designated to coordinate medical supports and services which the individual requires to manage any chronic health conditions and to access preventative healthcare services;

(9) others: unless the individual objects, other participants may include family members not already mentioned, if invited by the individual or the ISP development process on the individual's behalf; representatives of general services, who may participate in the IDT with the individual's or guardians' consent; representatives of the public school system, if the individual is of school age and attends public school; and, any others that the individual wishes to have attend the IDT meeting.

[8.371.5.11 NMAC - N, 7/1/2024]

8.371.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS:

A. Prior to the initial IDT meeting the case manager shall provide the individual and guardian, if any, with an orientation to the person-centered planning process, purpose of the ISP and roles and responsibilities of IDT members. After completion of the ISP, the individual and guardian shall be offered the opportunity to meet with the case manager and ask questions regarding the completed ISP within 30 days of the meeting, if desired.

B. The IDT shall be convened at least annually and may be convened as frequently as conditions or circumstances warrant to review and modify the ISP. If an ISP includes programs or services which restrict an individual or a behavioral program subject to the DDSD behavior support policy, the IDT shall review the relevant program or service at least quarterly. In situations where an individual is at risk of significant harm, the team shall convene within one working day, in person or by teleconference. If necessary, the ISP

shall be modified accordingly within 72 hours.

C. The IDT meeting shall be scheduled and conducted by the case manager who will solicit and facilitate the full participation of all team members. The individual shall be present unless he/she chooses not to attend. If any member is unable to attend IDT meetings, arrangements for their involvement shall be made through teleconference, designated representatives, or in the case of ancillary services, written reports provided to the case manager prior to the meeting.

D. The case manager shall provide written notice of the annual IDT meeting at least 21 days prior to the meeting. Notice shall be provided to the individual, their representative, guardian, providers and other invited participants. The case manager shall consult IDT members prior to scheduling the meeting in order to determine the best dates and times. The case manager shall attempt to accommodate team member's scheduling needs shall be accomodated as long as the timing does not jeopardize continued eligibility for the DD Waiver. A request for a change of meeting date made by the individual and guardian. Written documentation of notice and scheduling activities will be maintained by the case manager in the individual's records.

E. For state general funded services, the initial IDT meeting shall be held within 60 days of the start of services, and then annually thereafter. For all other developmental disabilities medicaid waiver recipients, the IDT meeting shall be held annually based upon the previous or initial ISP approval date.

F. In the event the individual or guardian requests that others be invited to attend the IDT meeting, the case manager shall also provide them with notification of the meeting.

G. The case manager will convene the IDT on an "as needed" basis to modify (revise or amend) the ISP once it has been developed. Participants may attend through teleconference.

H. The IDT shall be convened to discuss and modify the ISP, as needed, to address:

(1) a significant life change, including a change in medical condition or medication that affects the individual's behavior or emotional state;

(2) situations where an individual is at risk of significant harm. In this case the team shall convene within one working day, in person or by teleconference; if necessary, the ISP shall be modified accordingly within 72 hours;

(3) changes in any desired outcomes, (e.g. desired outcome is not met, a change in vocational goals or the loss of a job);

(4) the loss or death of a significant person to the individual;

(5) a serious accident, illness, injury or hospitalization that disrupts implementation of the ISP;

(6) individual, guardian or provider requests for a program change or relocation, or when a termination of a service is proposed; the DDSD's policy no. 150 requires the IDT to meet and develop a transition plan whenever an individual is at risk of discharge by the provider agency or anticipates a change of provider agency to identify strategies and resources needed; if the individual or guardian is requesting a discharge or a change of provider agency, or there is an impending change in housemates the team must meet to develop a transition plan;

(7) situations where it has been determined the individual is a victim of abuse, neglect or exploitation;

(8) criminal justice involvement on the part of the individual (e.g., arrest, incarceration, release, probation, parole);

(9) any member of the IDT may also request that the team be convened by contacting the case manager; the case manager shall convene the team within 10 days of receipt of any reasonable request to convene the team, either in person or through teleconference;

(10) for any other reason that is in the best interest of the individual, or any other reason deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the desired outcomes of the ISP and the long term vision of the individual;

(11) whenever the DDSD decides not to approve implementation of an ISP because of cost or because the DDSD believes the ISP fails to satisfy constitutional, regulatory or statutory requirements.

[8.371.5.12 NMAC - N, 7/1/2024]

8.371.5.13 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) ASSESSMENTS:

A. Assessment information, as described in Subsection C of 8.371.5.13 NMAC, shall be utilized to develop and revise the ISP. The individual, helper, family members and friends shall be provided an opportunity to present their perceptions regarding the individual's progress and current status. The observations and perceptions of people who know the individual well shall be considered when decisions regarding the ISP are made.

B. All IDT members shall review clinical and other assessments and evaluations completed on behalf of the individual. These assessments must be prepared with enough time for adequate review prior to the annual IDT meeting. Service providers preparing written assessment reports shall be responsible for submitting these documents to the IDT members at least two weeks prior to the scheduled annual IDT meeting. The case manager shall review written assessment reports with the individual and guardian prior to the IDT meeting.

C. Relevant IDT members, including ancillary service providers, shall prepare reports at least two weeks in advance of the IDT

meeting, based on their assessments of the individual's progress and current status in the domain for which they are responsible. Reports shall include, at a minimum, a client individual assessment (CIA) and a long term care abstract (LOC) completed by the case manager at least annually in consultation with the IDT; adaptive behavior scales completed by relevant IDT members; assessments from the various disciplines providing services to the individual (such as vocational evaluations, physical therapy evaluations, history and physical, etc.); objective data to corroborate evaluation information; reports by progress residential and day program providers; information, historical or otherwise, provided by guardians or family members; direct observations, especially during transitional periods. IDT members shall report other relevant information depending on the individual's service needs. Assessments shall be performed in settings normally utilized whenever possible.

D. When the IDT determines further independent assessment is needed, the team shall develop action plans within the ISP that addresses the need for such an assessment, including responsibility and timelines. Implementation of any action plan related to independent assessment shall be monitored by the case manager.

E. At the IDT meeting, team members shall:

(1) elicit and develop the individual's long term vision statement;

(2) review and discuss clinical and other assessments and evaluation reports in relation to the individual's abilities, interests, preferences and desired outcomes;

(3) review objectives, quantifiable data information from the previous ISP to determine the effectiveness of services and interventions and use this information when determining new or revised outcomes, action plans and strategies for the ISP under development;

(4) use the comprehensive compilation of client assessment information and the long term vision statement to perform a functional assessment; this functional assessment identifies the supports and services needed in assisting the individual in the attainment of the long term vision; for example, the functional assessment may evaluate the use of an interpreter as a support or assistive communication devices, environmental modifications, etc.; and

(5) the functional assessment shall reflect the experience, choices, cultural background, skills, needs and abilities of the individual; this functional assessment precedes the development of the action plan at the IDT meeting; functional assessments shall reflect the individual's current skills and abilities in relation to the individual's environment and community; functional assessments shall include the interpretation of clinical assessments and evaluations in assisting the individual in meeting the long term vision.

[8.371.5.13 NMAC - N, 7/1/2024]

8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain.

A. Demographic information: The individual's name, age, date of birth, important identification numbers (ie., medicaid, medicare, social security numbers), level of care address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance.

B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community.

C. Outcomes:

(1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP.

(2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities meadicaid waiver.

D. Individual preference: The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances, and interests of the individual, shall determine the life area relevance, if any to the individual's ISP.

E. Action plans:

(1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step.

(2) Service providers shall develop specific action

plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT.

(3) The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress.

(4) Provider agencies shall use formats to complete strategies relating to the ISP action plans during or after the IDT meeting. Separate provider agencies working to coordinate specific strategies to achieve the same action plans shall develop their strategies jointly. Service provider agencies shall develop strategies that are clearly integrated and associated with the individual's long term vision, outcomes, action plans and therapy recommendations identified by the IDT. Therapists shall provide input into the development of strategies either directly or through review and revision prior to submission to the case manager. Provider agencies shall submit strategies for inclusion into the ISP to the case manager within two weeks following the ISP meeting. The case manager shall review the strategies for consistency.

(5) Supports and services, including services available to the general public, determined by the IDT and indicated in the ISP, shall be relevant to the individual's long term vision, desired outcomes and action plans. Supports and services shall be the least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

F. Assistive technology: Necessary support mechanisms devices, and environmental modifications including the rationale for the use of assistive technology or adaptive equipment when a need has been identified, shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as nonintrusive a fashion as possible.

G. Availability of supports and services:

(1) Identification of potential supports and services for individuals by the IDT should be undertaken without regard to the cost of the supports and services or whether they are actually available at the time in the community.

(2) For individuals who receive services through state general fund or developmental disabilities medicaid waiver but who are NOT *Jackson* class members, the IDT, exercising professional judgment, may take into account the availability of supports and services in specifying in the ISP the supports and services required to be provided. If supports or services are identified in the ISP, but not required to be provided in the exercise of professional judgment taking into account the availability of services, the IDT shall promptly submit a list of these unavailable supports and services to the DDSD.

(3) For *Jackson* class members, the ISP shall include the supports and services identified by the IDT.

(4) The DDSD shall use these lists to identify appropriate community resource needs and develop strategies to add community supports and services, generally, for persons with developmental disabilities, subject to appropriations for this purpose.

H. Signature form:

(1) A signature form, containing the name, phone number and role on the IDT of all team members shall be included in the ISP. All individuals participating in the annual IDT meeting shall sign the signature form to indicate their participation in the planning process.

(2) Signing this form does not affect the individual's or guardian's right, if any, to dispute all or part of the ISP or to initiate a complaint or grievance procedure. The case manager shall explain the right to dispute or to file a grievance to the individual and guardian at the IDT meeting. The case manager shall inform the individual and guardian of the DDSD, office of quality assurance, its role and function in monitoring services in the community, as well as the role and function of any other relevant monitoring agencies, such as the licensing and certification bureau of the division of health improvement and adult protective services program of the aging and long term services department. The case manager shall give the individual and guardian their business address and phone number, as well as the 800 number of the DDSD's office of quality assurance and other relevant numbers.

I. Budget page: For individuals receiving services through the developmental disabilities medicaid waiver, a proposed budget page developed by the case manager in consultation with the various service providers shall be included in the ISP.

[8.371.5.14 NMAC - N, 7/1/2024]

8.371.5.15 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - APPROVAL OF THE ISP BY THE DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION:

A. The ISP for recipients of the medicaid developmental disabilities waiver services (including *Jackson* class members) must be reviewed by the DDSD as to the cost of the individual's ISP and aggregate costs of ISPs and as to compliance with DDSD standards and medicaid regulations. If the DDSD does not approve an ISP because of cost or non-compliance, the ISP will be returned to the IDT with appropriate instructions to develop an ISP that meets requirements and is within the DDSD's budget parameters. The

ISP for developmentally disabled medicaid waiver recipients (including *Jackson* class members) shall not be implemented until approval by the DDSD.

B. Because cost limitations are established upfront in the contracting process for persons funded solely by state general funds, the above ISP review and approval process (per Subsection A of 8.371.5.15 NMAC above) is not required. The DDSD reserves the right to conduct on-site review for compliance with these regulations.
[8.371.5.15 NMAC - N, 7/1/2024]

8.371.5.16 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - IMPLEMENTATION OF THE ISP: The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan.
[8.371.5.16 NMAC - N, 7/1/2024]

8.371.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:

A. The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within 14 days of ISP approval to:

(1) the individual;

(2) the guardian (if applicable);

(3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons;

(4) all other IDT members in attendance at the meeting to develop the ISP;

(5) the individual's attorney, if applicable;

(6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies;

(7) for all developmental disabilities mediciad waiver recipients, including *Jackson* class members, a copy of the completed ISP containing all the information specified in 8.371.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD;

(8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD.

B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.

C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.

D. The ISP shall be consistent with all relevant health care authority and DDSD rules, policies, procedures operational guidelines, including, but not limited to, the HCA operational procedures; standards and applicable accreditation standards approved by the authority and DDSD; the behavioral support policy, the *Jackson* management manual (appendices A and B); the medicaid waiver operations manual; the program standards for DD community agencies; the case manager standards and client rights regulations. Confidentiality and individual rights shall be protected at all times.

E. For *Jackson* class members, the request to initiate a dispute under appendix B of the *Jackson* management manual shall automatically delay implementation of the disputed portions of the ISP until the dispute is resolved unless the health or safety of the individual would be adversely affected. Any dispute raised under appendix B shall be decided under the hearing officer guidelines for decisions contained in the appendix.

F. Nothing in this regulation shall provide an entitlement to programs, supports, services or benefits or create any legal rights that do not otherwise exist under other law or regulation.

G. The health care authority's decision regarding the allocation of resources to any ISP is final, (within the HCA) in the authority's sole discretion, and is not reviewable in the dispute resolution process or other agency administrative review process.

H. Community service provider agencies and case management agencies shall modify or amend their internal policies and procedures regarding ISP development to reflect the provisions stated within the ISP regulations. All ISPs and all modifications to ISPs shall be developed in compliance with these regulations.
[8.371.5.17 NMAC - N, 7/1/2024]

8.371.5.18 SANCTIONS. The authority or other governmental agency having regulatory enforcement authority for community based services provider agencies who have entered into contracts or medicaid provider agreements with the health care authority, developmental disabilities supports division, may sanction in accordance with applicable law if the service provider fails to provide services as set forth by this rule. Such sanctions may include revocation or suspension of license, directed plan of correction, intermediate sanctions or civil monetary penalty up to $5000 per instance, or termination or non-renewal of any contract with the

authority or other governmental agency.
[8.371.5.18 NMAC - N, 7/1/2024]

HISTORY OF 8.371.5 NMAC: [RESERVED[

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 371 DEVELOPMENTAL DISABILITIES
PART 6 REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES COMMUNITY PROGRAMS

8.371.6.1 ISSUING AGENCY: New Mexico Health Care Authority, Developmental Disabilities Division.
[8.371.6.1 NMAC - N, 7/1/2024]

8.371.6.2 SCOPE: These regulations apply to all community agencies who have entered into contracts or medicaid provider agreements with the health care authority, developmental disabilities division, to provide services to persons with developmental disabilities.
[8.371.6.2 NMAC - N, 7/1/2024]

8.371.6.3 STATUTORY AUTHORITY: Sections 28-16-7 and 28-16-8, NMSA 1978, (the Developmental Disabilities Community Services Act) and Subsection E of Section 9-8-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.
[8.371.6.3 NMAC - N, 7/1/2024]

8.371.6.4 DURATION: Permanent.
[8.371.6.4 NMAC - N, 7/1/2024]

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

8.371.6.6 OBJECTIVE:
A. These regulations are being promulgated to promote and assure the provision of quality services to persons with developmental disabilities residing in community agencies.
B. These regulations are being promulgated as part of a quality assurance initiative requiring all community agencies providing services to persons with developmental disabilities and contracting with the developmental disabilities division to be accredited by the commission on accreditation of rehabilitation facilities (CARF).
[8.371.6.6 NMAC - N, 7/1/2024]

8.371.6.7 DEFINITIONS:
A. "Adult" means an individual who has attained the age of 18 years.
B. "Community agency" means any nonprofit or for profit corporation, tribal organization, unit of local government, or other organization which has entered into a contract with the authority for the purpose of providing developmental disabilities services.
C. "Community living setting" refers, for the purpose of these regulations, to a community living situation supervised by a community agency, which:
(1) provides living arrangements for persons with a developmental disability; and
(2) is located in the community. Such facilities may include licensed group homes, foster homes, family living situations, supported living situations, companion homes, semi-independent living and assisted living residences or similar residences or innovative residential settings. When personal care and respite services are the sole services provided to the individual, these services are not included under the definition for "community living setting" as long as they are provided in the individual's or family's personal home which is not under the direct auspices or control of the community agency.
D. "Consent screening instrument" means the instruments or procedures for determining an adult's ability to give informed consent to a residential placement as the authority will designate.
E. "Court" means a New Mexico state district court.
F. "Developmental disability" means a severe chronic disability of a person which is attributable to a mental or physical impairment, including the result of trauma to the brain, or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity:
(1) self-care;
(2) receptive or expressive language;
(3) learning;
(4) mobility;
(5) self-direction;
(6) capacity for independent living;
(7) economic self-sufficiency; and
(8) reflects the person's need for a combination and sequence of special interdisciplinary or generic care treatment or other services that are of life-long or extended duration and which are individually planned and coordinated.
G. "Developmental delay" is defined as a discrepancy between chronological age, after correction for prematurity, and developmental age in one or more of the following areas of development: cognitive, communication, physical/motor (including vision and hearing), social/emotional, or adaptive.
(1) Eligibility: To be eligible for services, a child must demonstrate twenty-five percent or more discrepancy between chronological age, after correction for prematurity, and developmental age.

The extent of the child's delay must be documented. A determination of developmental delay shall not be based upon behavior related to cultural or language differences.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "Policies, Procedures and Guidelines for the Family, Infant, Toddler Program (FIT)". The procedures may include informed clinical opinion, norm-referenced/ standardized measures, criterion-referenced/curriculum-based instruments, behavior checklists and adaptive behavior measures.

H. "Established condition" is defined as a diagnosed physical, mental or neurobiological condition which has a high probability of resulting in developmental delay. A delay in development may or may not be exhibited at the time of the diagnosis. Examples of an "established condition" include, but are not limited to: down's syndrome, and other chromosomal abnormalities associated with delays in development; congenital and postnatal conditions associated with delays in developmental, such as sensory impairments (including vision and hearing), inborn errors of metabolism, myelomeningocele, cerebral palsy, fetal alcohol syndrome, non-febrile seizures, malignancy of the brain or spinal cord, acquired immune deficiency syndrome (AIDS), hydrocephaly, and infections such as cytomegalovirus (CMV), herpes or encephalitis; neurobiological conditions such as autism or other pervasive developmental disorders.

(1) Eligibility: The determination of the presence of an established condition is identified by a physician or other primary health care provider. The diagnosis of the condition(s) establishes eligibility.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "policies, procedures and guidelines for the family, infant, toddler program (FIT)".

I. A **"Biological or medical risk for developmental delay"** is the presence of early medical conditions which are known to produce developmental delays in some children. Examples of "biological or medical risk" include, but are not limited to, the following medical conditions: pre-term birth of less than 32 weeks gestation; very low birth weight (less than 1500 grams or three pounds, four ounces); periventricular intraventricular hemorrhage (PIVH); periventricular leukomalacia (PVL); hypoxic ischemic encephalopathy (birth asphyxia); chronic lung disease (CLD) of prematurity or bronchopulmonary dysplasia (BPD); prenatal exposure to drugs or medications or other teratogens known to be associated with developmental delays; failure to thrive; chronic otitis media.

(1) Eligibility: The determination of the presence of biological/medical risk condition(s) is identified by a physician or other primary health care provider (PHCP). The diagnosis of the condition(s) establishes eligibility.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "policies, procedures and guidelines for the family, infant, toddler program (FIT)".

J. An **"Environmental risk for developmental delay"** is the presence of physical, social or economic factors in the environment which pose a substantial threat to development. Examples of "environmental risk" are usually a combination of more than one factor which may include, but are not limited to: Parental developmental disabilities or psychiatric disorders; parental substance abuse; child abuse or neglect; homelessness; exposure to domestic or other episodes of violence.

(1) Eligibility: The determination of the presence of eligible environmental risk factors must be established by a multi-agency team.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "policies, procedures and guidelines for the family, infant, toddler program (FIT)".

K. "Guardian" means for purposes of these regulations a guardian, limited guardian or guardian ad litem as defined in Section 45-1-21 NMSA 1978 or as may be subsequently amended.

L. "Person" or "person served" means individuals with "developmental disabilities", "developmental delay", "established condition" or "at risk for developmental delay (biological/ medical risk or environmental risk)" as defined within these regulations, currently receiving or waiting to receive services.
[8.371.6.7 NMAC - N, 7/1/2024]

8.371.6.8 ELIGIBILITY FOR SERVICES:

A. Community agencies shall establish clearly written criteria for eligibility which correspond with the definitions of "developmental disability", "developmental delay" and "at risk for developmental delay" as defined within these regulations:

B. Community agencies shall have written procedures for notifying the person(s) served of their eligibility status.
[8.371.6.8 NMAC - N, 7/1/2024]

8.371.6.9 CONSENT

SCREENING FOR PERSONS ENTERING COMMUNITY LIVING FACILITIES:

A. Prior to admission into a community living setting, community agencies shall convene an interdisciplinary team (IDT) to determine if the person served has the ability to consent to a residential placement or is likely to need consent screening. This determination and its justification is to be documented in writing. If the IDT determines:

(1) that the person served does not need consent screening, then the person served should at this point be given the option to accept or reject the community agency's services.

(2) that the person served needs consent screening, the ability to consent should then be determined using the consent screening instrument.

B. The community living setting will have a written review process that provides an expedient means to re-evaluate the person's ability to give consent. The process shall describe steps in the procedure and timelines governing the procedure.

C. If the person served is found able to give consent then they should have the option to accept or reject the community agency's services.

D. At any time the person served or guardian believes the person served has the ability to give consent, they can have their consent status reviewed and request a new consent screening.

E. The need for consent screening should be reviewed by the IDT at least once a year.

(1) If the person served did not pass the consent screening at the time of the initial admission, then the consent screening must be administered within one year and annually thereafter.

(2) If the person served was able to give consent, the IDT will be required to review the need to administer the consent screening instrument when it has reasonable grounds for believing that the client may no longer be capable of providing consent.

[8.371.6.9 NMAC - N, 7/1/2024]

8.371.6.10 ADMISSION TO COMMUNITY LIVING SETTINGS:

A. If the person served is found able to consent and agrees to be admitted to the community living-setting they shall record their signature or make other appropriate designation of approval on the admissions document.

B. If the person served is found able to consent and the IDT indicates that the person served would benefit from placement in a community-living setting, but the person served refuses such placement attempt, then the person served may be admitted only upon involuntary commitment under Sections 43-1-13 NMSA 1978, or 43-1-11 NMSA 1978 and 43-1-12 NMSA 1978 of the New Mexico Mental Health and Developmental Disabilities Code.

C. If the person served is found not able to give consent and the IDT indicates that the person served would benefit from placement in a community-living setting, then the program may not admit the person without the consent of a guardian legally authorized to provide or withhold such consent. The exception would be in the case of an emergency admission for a period not to exceed 90 days, pursuant to 8.371.6.12 NMAC.

[8.371.6.10 NMAC - N, 7/1/2024]

8.371.6.11 WAITING LIST: The authority shall maintain an up-to-date waiting list consisting of all persons who need placement in a community living-setting, but are not yet placed in a community living setting. Any program with an opening in a community living-setting may select any person from the waiting list of persons from the developmental disabilities bureau of the authority who has been evaluated for admission to the community living-setting. A person should not be admitted to a community living setting unless the community agency agrees to serve that person.

[8.371.6.11 NMAC - N, 7/1/2024]

8.371.6.12 EMERGENCY SERVICES:

A. Services in a community living setting may be provided on an emergency basis to any person believed to be developmentally disabled when a community agency determines that there is imminent danger that the physical health or safety of the person will be seriously impaired if the services are not provided, and that the normal admissions procedure, including consent screening and evaluation, cannot be accomplished in time to avoid danger.

B. When emergency services are provided, the community agency should document the nature of the emergency resulting in services being provided.

C. When the person served is receiving emergency services, the community agency should evaluate the person in a timely manner to determine if the person served will continue to receive services from their community agency.

D. Emergency services should not be provided for more than seven days unless an evaluation has begun, or, for more than 21 days in total, unless a court or the authority orders otherwise.

[8.371.6.12 NMAC - N, 7/1/2024]

8.371.6.13 NOTICE OF THE DEATH OF A PERSON SERVED:

A. The agency shall have policies and procedures regarding the death of a person under supervision of the agency. These policies and procedures shall include:

(1) staff responsibilities and protocols for handling the immediate situation;

(2) person(s) to be notified and procedure for notification;

(3) provisions for disposal of estate and person's funds, when person has no relevant person(s) to perform these duties.

B. If termination of

services is the result of a person's death, the following information shall be prepared for the person's file and sent to the authority:

(1) time and date of person's death;

(2) cause of death;

(3) circumstances surrounding death;

(4) medical/ autopsy report;

(5) summary of any follow-up findings relating to the death.

[8.371.6.13 NMAC - N, 7/1/2024]

8.371.6.14 CARF STANDARDS MANUAL FOR ORGANIZATIONS SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES: Community agencies governed by these regulations are required to meet applicable provisions of the most current edition of the "*CARF standards manual for organizations serving people with disabilities*". Sections of the CARF standards may be waived by the authority when deemed not applicable to the services provided by the community agency.

[8.371.6.14 NMAC - N, 7/1/2024]

HISTORY OF 8.371.6 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 371 DEVELOPMENTAL DISABILITIES
PART 7 (APPENDIX A) INDIVIDUAL TRANSITION PLANNING PROCESS

8.371.7.1 ISSUING AGENCY: New Mexico Health Care Authority, Developmental Disabilities Division.

[8.371.7.1 NMAC - N, 7/1/2024]

8.371.7.2 SCOPE:

A. The regulations provide a systematic process for the individualized planning and implementation of a developmentally disabled resident's transition from the two large, state-operated institutional facilities into a community setting.

B. The ITP process described in this document is intended to develop a proposed community placement for an individual based upon the individual's preferences and upon community service provider selections made generally by the individual's parent/guardian in consultation with the individual. As specified in Activity 19, below, the placement proposal developed by this process is subject to the health care authority review of the cost of the individual's plan or aggregate costs.

[8.371.7.2 NMAC - N, 7/1/2024]

8.371.7.3 STATUTORY AUTHORITY: Section 9-7-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.371.7.3 NMAC - N, 7/1/2024]

8.371.7.4 DURATION: Permanent.

[8.371.7.4 NMAC - N, 7/1/2024]

8.371.7.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.371.7.5 NMAC - N, 7/1/2024]

8.371.7.6 OBJECTIVE:

A. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in *Jackson, et al, v. Fort Stanton*, et al., N.M. Dist. Ct. No. Civ. No. 87-839. The transition process appearing in these regulations has evolved over time, initially appearing as Appendix A to the Jackson Management Manual. This transition planning process history accounts for the continuing reference in the regulation title to Appendix A. The regulations embody certain agreements and arrangements reached by the parties to the *Jackson* lawsuit. And they reflect the developmental disabilities division's cumulative experience in planning and administering the transition process.

[8.371.7.6 NMAC - N, 7/1/2024]

8.371.7.7 DEFINITIONS: The transition interdisciplinary team:

A. The individual: The individual with a developmental disability must participate to the greatest extent possible. There must be a serious effort to ensure that the individual is present and that they, even when lacking verbal skills, are given the opportunity to express their interests, choices and strengths. However, no individual shall be compelled to participate in the planning process. The individual's normal daily routine and schedule should be followed as much as possible on days when meetings occur; special accommodations for the individual should be identified prior to each meeting and appropriate adjustments and modifications in the meeting should be planned to enable them to participate as fully as possible. An individual may choose someone to represent them consistent with their wishes in the TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

B. The parent/ guardian: As used in these procedures, the phrase "parent/ guardian" shall mean the individual's legal guardian or, if the individual is a minor, the individual's parent(s). The division shall attempt to inform and involve the parent/guardian in the transition planning process, including making reasonable scheduling accommodations and providing interpreters as necessary.

C. The helper: The helper is someone who knows the individual's capabilities, interests, likes and dislikes and who communicates with the individual. The helper may be a friend, roommate, family member,

teacher, co-worker, current or former employee of the institutional facility, foster grandparent, or any other person from the individual's circle of relatives, friends, or acquaintances.

D. The social worker: The social worker should be the social worker at the facility, i.e., either Los Lunas or Fort Stanton, who has worked with the individual or, if unavailable, the social worker who has been assigned.

E. Facility interdisciplinary team (IDT) members: Facility interdisciplinary team members, designated pursuant to division *Jackson* office policy memoranda, who have been trained to participate in the transition process and who have knowledge of the individual shall assist with ITP planning, implementation and follow-up, as required.

F. Jackson transition representative (JTR): The *Jackson* transition representative (JTR) is the division's representative at transition meetings and activities.

G. Key community service providers: Key community service providers are selected prior to the TIDT meeting pursuant to Activity 7. The term key community service providers means the community residential provider and other providers of significant services for the individual, including but not limited to the competitive and supportive employment provider, medical professional(s) if the individual's medical condition so requires, and other support service providers identified by the expanded IDT as key community service providers. When the individual is of school age, a representative of the local education agency is a key community service provider.
[8.371.7.7 NMAC - N, 7/1/2024]

8.371.7.8 INTRODUCTION:

A. There are two planning components that must be accomplished concurrently:

(1) planning and effecting the move for each individual who will be moving; and

(2) planning and preparing the system of community supports.

B. This document provides the process by which each individual transition plan (ITP) shall be developed. The *Jackson* systemic plan and *Jackson* management manual address the preparation of the system of community placements and supports. These documents have been developed so that the systemic components are consistent with and support the proposed means of individualized planning and placement.

C. The developmental disabilities division, hereinafter "division", is committed to preparing and implementing ITPs expeditiously, consistent with professional judgement. The ITP process reflects the fact that New Mexico is currently seeking to create a system of supports and services for individuals who are moving from institutional facilities to community living. The division anticipates that as its service system for individuals with developmental disabilities expands, the time associated with several activities may be shortened. Therefore, prior to October 1, 1994, the division shall review its experience in implementing these procedures to determine whether any of the provisions may be modified and particularly whether any of the time periods should be shortened. These procedures shall remain in effect unless modified by the division after consultation with the parties in *Jackson et al. v. Fort Stanton et al.,* Civ. No. 87-839 JP. The health care authority, hereinafter, "the authority", intends that the procedures described herein shall be consistent with federal regulations and requirements. If there is a conflict between these procedures and the federal regulations and requirements, the federal regulations and requirements shall govern.
[8.371.7.8 NMAC - N, 7/1/2024]

8.371.7.9 BASIC CONCEPTS AND ITP DEVELOPMENT GUIDELINES:

A. Individual transition planning is founded on the following basic concepts:

(1) Individual transition planning strives for the goal that the individual can live in and be a part of a community in the same manner and to the same extent as would any other person of like age and interests.

(2) There are no starting assumptions based on models of service. Planning is not performed in order to fit an individual into existing models of service, but rather to tailor necessary supports to the individual who is moving, through uniquely individualized planning.

(3) Supports and services are provided to the extent there is a demonstrated individual need, and no more.

(4) All persons have strengths and interests and are capable of growth and development, at differing paces.

(5) Successful human planning starts from and builds on individual strengths and interests, not deficits.

(6) Human planning must be flexible and responsive to changing individual circumstances and environments.

B. The TIDT shall develop the ITP in accordance with the following guidelines:

(1) The contents of the ITP are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(2) The ITP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable of communicating any preference.

(3) The ITP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible and consistent with the individual's needs.

(4) The ITP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

(5) The ITP can be practicably implemented.

[8.371.7.9 NMAC - N, 7/1/2024]

8.371.7.10 THE INTERDISCIPLINARY TEAM: Each individual residing at Los Lunas or Fort Stanton hospital and training school has an interdisciplinary team (IDT), which is responsible for developing the individual program plan (IPP) as long as the individual resides in the facility. It is the individual's IDT that, among its other activities, has the responsibility for recommending the individual for community placement. Once that recommendation is made, transition planning is begun. To successfully accomplish the development of an ITP, each individual's IDT shall expand to include community membership and become the transition interdisciplinary team (TIDT).
[8.371.7.10 NMAC - N, 7/1/2024]

8.371.7.11 THE TRANSITION INTERDISCIPLINARY TEAM (TIDT):

A. In order to develop a transition plan that is tailored to the individual, and in order to help achieve successful placement of the individual in the community, the IDT shall expand to include a number of non-professionals, managers and prospective community service providers, as well as the IDT's professionals. There is no universal combination of persons necessary for the TIDT meeting. The individual's participation at the TIDT meeting is necessary unless the individual objects. The participation of the parent/guardian at the meeting is usually required unless the absence is by choice or by necessity. The persons who comprise the TIDT shall normally be present at the TIDT meeting, but in the absence of any person, the team members may proceed with the individual planning process if those present determine it to be appropriate under the circumstances.

B. The TIDT shall usually include the following persons:

(1) The Individual: The individual with a developmental disability must participate to the greatest extent possible. There must be a serious effort to ensure that the individual is present and that he or she, even when lacking verbal skills, is given the opportunity to express their interests, choices and strengths. However, no individual shall be compelled to participate in the planning process. The individual's normal daily routine and schedule should be followed as much as possible on days when meetings occur; special accommodations for the individual should be identified prior to each meeting and appropriate adjustments and modifications in the meeting should be planned to enable them to participate as fully as possible. An individual may choose someone to represent them consistent with their wishes in the TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

(2) The parent/guardian:

(a) The division shall attempt to inform and involve the parent/guardian in the transition planning process, including making reasonable scheduling accommodations and providing interpreters as necessary.

(b) If by 30 days prior to the transition interdisciplinary team (TIDT) meeting described in Activity 11 a parent/guardian has advised the division that the guardian is unwilling or unable to be an active participant during the transition planning process, the division shall seek prompt modification of the guardianship and, if needed, appointment of a co-guardian or a successor guardian to ensure that the individual's guardian, if any, is an informed and active participant in the planning process. A parent/guardian may choose someone to represent him/her consistent with his/her wishes in TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

(3) The helper:

(a) The role of the helper is to assist the individual in participating in the transition planning process by helping the individual to communicate his or her interests, likes and dislikes to other TIDT members. The same helper should be available throughout the transition process. Whenever the helper is a facility employee, accommodation should be made to facilitate his/her availability for all meetings.

(b) The individual can select their helper. For those individuals who do not select a helper, but do not object to the assistance of a helper, the facility's director of social work shall identify a qualified helper. If necessary, the division shall reimburse the helper for reasonable travel expenses incurred solely to visit the individual at least once before the TIDT meeting and to attend TIDT meeting(s) described in Activity 11.

(4) The social worker:

(a) The social worker should be the social worker at the facility i.e., either Los Lunas or Fort Stanton, who has worked with the individual or, if unavailable, the social worker who has been assigned.

(b) The social worker shall work with the case manager on behalf of the facility to assist with the proposed transition and any follow-up support as required.

(5) The case manager:

(a) The case manager should be the individual selected or assigned pursuant to activity 2.

(b) The case manager shall have a good working knowledge of the available generic and specialized services in the geographic area to which the individual will be moving. The case manager, in addition to the duties described herein and in the *Jackson* management manual, shall review the bi-weekly reports of the *Jackson* office on the status of pre-

placement activities and monitor ITP implementation at the facility and in the community and shall review the ITP and the community programs identified for the individual immediately prior to the move to ensure the necessary supports and services are in place.

(6) Facility interdisciplinary team (IDT) members: Facility interdisciplinary team members, designated pursuant to division *Jackson* office policy memoranda, who have been trained to participate in the transition process and who have knowledge of the individual shall assist with ITP planning, implementation and follow-up, as required.

(7) *Jackson* transition representative (JTR): The *Jackson* transition representative (JTR) is the division's representative at transition meetings and activities. This individual's primary purpose shall be to assist in identifying community service providers and facilitating and documenting the transition planning process.

(8) Key community service providers: Key community service providers are selected prior to the TIDT meeting pursuant to Activity 7. The term key community service providers means the community residential provider and other providers of significant services for the individual, including but not limited to, the competitive and supportive employment provider, medical professional(s) if the individual's medical condition so requires, and other support service providers identified by the expanded IDT as key community service providers. When the individual is of school age, a representative of the local education agency is a key community service provider, and should be present at transition planning meetings.

C. The individual and or the parent/guardian may invite other individuals to attend TIDT meetings. Parents or family members who are not guardians of an adult individual may be invited, unless the adult individual objects. Voting privileges are limited to TIDT core group members, pursuant to DDD *Jackson* office policy memoranda. Scheduling of the TIDT meeting(s) shall not be delayed for the convenience of these "other individuals" who have been invited to attend, nor rescheduled if such "other individuals" fail to attend.
[8.371.7.11 NMAC - N, 7/1/2024]

8.371.7.12 PREPARATION FOR PARTICIPATION IN TRANSITION PLANNING: In order to prepare team members for participation in the team process, the following activities, as provided in the *Jackson* systemic plan and management manual should occur:

A. Team members who are staff of the health care authority or of the case management agencies providing services on behalf of the state shall be trained in the TIDT process.

B. The case manager and the helper shall meet with and provide assistance to the individual so that the individual understands and is prepared to participate in the TIDT process to the extent possible.

C. The case manager shall meet with the parent/guardian and provide information on the TIDT process.

D. The information developed for the individual and parent/guardian pursuant to the *Jackson* Management Manual shall be provided to the individual and parent/guardian.

E. The authority shall provide for an interpreter, if necessary, and for transportation for the parent/guardian to attend team meetings as needed.
[8.371.7.12 NMAC - N, 7/1/2024]

8.371.7.13 THE PROCESS FOR THE DEVELOPMENT OF THE INDIVIDUAL TRANSITION PLAN (ITP) - TIME LINES:

A. The individual transition plan (ITP) process provides timelines by which specific actions are scheduled to occur. Although the health care authority intends to accomplish the specified activities within the time lines provided, the quality of individual program planning and the involvement of the individual will not be compromised in order to achieve a specific time line.

B. The health care authority shall provide to the plaintiffs and plaintiff-intervenors a "planning initiation schedule" on a quarterly basis that will identify the date by which Activity 11, the TIDT meeting, shall be initiated for each individual on the schedule. The initial transition interdisciplinary team (TIDT) meeting is scheduled by the *Jackson* office of the developmental disabilities division (DDD) upon the recommendation of the facility IDT for community placement. Except as provided herein, effective August 1, 1994, and thereafter, the initial transition interdisciplinary team (TIDT) meeting will be scheduled within sixty days of a community placement recommendation of the facility interdisciplinary team (FIDT). If, as of July 31, 1994, new Los Lunas center for persons with developmental disabilities FIDT community placement recommendations exceed one, but do not exceed two per month, the requirement to schedule the TIDT meeting within 60 days is effective September 1, 1994. If, as of July 31, 1994, new Los Lunas hospital and training school FIDT community placement recommendations exceed two per month, the requirement to schedule the TIDT meeting within 60 days is effective October 1, 1994. TIDT dates are fixed and subject to change only on condition of extraordinary circumstances, absence of key team members or due process initiation.

C. The time lines shall be extended only so long as necessary to accommodate:

(1) additional TIDT meetings, as determined by the TIDT under Activity 11 or the case manager under activity 17;

(2) a pending dispute pursuant to the dispute resolution process (DRP) for individual transition plans (see Activity 18 and 8.371.8 NMAC) dispute resolution process (Appendix

B); or

(3) extraordinary circumstances as determined by:

(a) the case manager under Activities 16 and 17, for example.or

(b) the *Jackson* coordinator as a result of significant changes in an individual's condition or circumstances.

(4) A delay for extraordinary circumstances is subject to review by the TIDT upon the request of the individual, the parent/guardian or their representative.

D. Absent such events, the division shall schedule and accomplish the activities identified below within the following time lines:

(1) TIDT meeting (Activity 11): No more than 228 days prior to placement, and as set by *Jackson* transition office calendar (absent extraordinary circumstances or judicial stay order); updated calendars submitted to the court;

(2) additional TIDTs (Activity 11): within 21 days of initial TIDT meeting;

(3) cost proposals (Activity 13 - 14): submitted 30 days after distribution of the ITP; reviewed within 30 days;

(4) ITPQA review meeting (Activity 17): scheduled at the final TIDT meeting; to occur 30 - 45 days prior to placement date.

E. Case manager activities (activities 2 - 9) may begin as early as 120 days, but no later than 90 days prior to the established initial TIDT meeting date.

F. Interim target time lines are more fully set forth below in the specific paragraph describing the activity. Activities 1 - 10 may begin for each individual at the division's discretion sufficiently in advance of the planning initiation schedule identified by the division. In no event shall activity 10 be completed later that 14 days before each individual's planning initiation date. Unless otherwise specified, days means calendar days.

[8.371.7.13 NMAC - N, 7/1/2024]

8.371.7.14 THE PROCESS FOR THE DEVELOPMENT OF THE INDIVIDUAL TRANSITION PLAN (ITP) - TRANSITION PLANNING ACTIVITIES:

A. Prior to the start of the formal transition process, the facility interdisciplinary team (FIDT) shall convene to conduct the annual IPP meeting. At this facility IDT meeting, the following transition activities shall be conducted:

(1) Review individual for community placement; if appropriate, make formal recommendation for community transition to begin and identify probable geographic area of community move. The individual and parent/guardian(s) shall, in consultation with the FIDT, choose the probable area of relocation.

(a) If a recommendation for community placement is made, the presumption is that the individual shall, if a child, move home with necessary supports, or, if an adult, move to the family's home town or nearby. This presumption may be altered by factors such as individual interest and choice, work interest and opportunities, friendships, families with competing interests, and the potential availability and costs of medical resources and other support services or service providers. The social worker shall notify the *Jackson* office of the facility of the individual's community placement recommendation and probable area of relocation within five days.

(b) After notification regarding an individual's probable area of relocation, the *Jackson* office shall add the individual to the transition planning calendar. The *Jackson* transition representative (JTR) shall inform the individual and the individual's parent/guardian of the identity of potential community service providers and the types of services the community service provider offers. The facility social worker and case manager, if already chosen, shall assist the individual and parent/guardian in making the community service provider selection (see Activity 7, below).

(2) Establish goals and objectives in the IPP that will facilitate the individual's transition, if community placement is recommended.

(3) Identify strengths and supports within the ten "life areas" (profile of supports form). Make support descriptions useful.

(4) Access regional office staff for community resource information and liaison. Identify generic resources in the area of relocation that could be utilized by the individual.

B. Transition planning for individuals recommended for community placement shall proceed after the facility IDT meeting with the following activities. Unless the context requires otherwise, activities may occur concurrently.

[8.371.7.14 NMAC - N, 7/1/2024]

8.371.7.15 ACTIVITY 1: SELECTION OF HELPER: At least 90 days before the TIDT meeting identified in Activity 11, the social worker shall contact the individual and, using appropriate communication assistance or aids, explain to the individual their right to identify a helper or representative to assist in the upcoming TIDT meetings and the right to invite any other person as provided in Section 11. The individual may refuse to have the assistance of a helper.

[8.371.7.15 NMAC - N, 7/1/2024]

8.371.7.16 ACTIVITY 2: CASE MANAGER ASSIGNED:

A. For the individual moving to the community the social worker shall, after identification of the probable area of relocation, provide the individual and mail to the parent/guardian a listing of eligible case management agencies that serve the individual's probable area of relocation. The *Jackson* transition representative (JTR) shall also provide the individual and the parent/guardian with the information

necessary for them to make an informed selection. The parent/guardian, in consultation with the individual, shall, within 21 days of the date the list was mailed, select a case management agency.

B. The social worker shall confirm, in writing, the selection of the agency with the individual, the agency, the parent/guardian and the case management unit of the community programs bureau of the DDD. The social worker shall identify the date by which a case manager must be assigned. The agency shall assign a case manager by the date contained in the written confirmation, which shall be no later than 90 days prior to the initial TIDT meeting described in Activity 11. The assigned case manager must be located in or close to the probable area of relocation but in no instance more than 150 miles from the probable area of relocation.

C. This activity is to be accomplished concurrently with Activity 7, selection of community service provider(s), whenever possible.

D. If, within 85 days of the established initial TIDT meeting described in Activity 11, the parent/guardian has not consulted with the individual and selected a case management agency, the authority shall consult with the individual and make the selection.

[8.371.7.16 NMAC - N, 7/1/2024]

8.371.7.17 ACTIVITY 3: MEETING WITH INDIVIDUAL:

A. The case manager shall meet with and, using appropriate communication assistance or aids and observation, get to know the individual. The case manager and the helper shall meet with and provide assistance to the individual so the individual understands and is prepared to participate in the TIDT process to the extent possible.

B. The case manager shall also explain to the individual and helper the process by which the individual's placement shall be designed and implemented, including the TIDT process for developing a proposed placement, the state's implementation decision described in Activity 19, and the process for resolving disputes. As appropriate, the case manager shall provide a copy of the ITP process, the DRP, and the case manager's phone number and address to the individual prior to or at the first meeting.

C. In addition, the case manager shall explain the selection of community service providers, Activities 6 and 7, and make all effort to encourage and expedite this selection, if it has not already occurred, prior to convening any transition meetings. The case manager shall encourage the individual's preference for living arrangements and housemates.

D. If the individual is not familiar with other persons who are identified as probable housemates, the individual will be offered an opportunity to meet with such persons. The individual shall be given an opportunity to approve or object to any identified housemates. The case manager shall communicate with the individual as frequently as necessary before placement to keep the individual informed and involved in the team process. The case manager shall inform the individual and helper that the individual may invite others to attend the TIDT meetings, and arrange co-scheduling of TIDTs where housemates are agreed to.

[8.371.7.17 NMAC - N, 7/1/2024]

8.371.7.18 ACTIVITY 4: RECORD REVIEW: Specified staff at the facility where the individual resides shall prepare a summary of the individual's record as set forth in the *Jackson* management manual, with particular attention to those historic events, medical or otherwise, that may affect community living design. The record summary shall be prepared pursuant to division *Jackson* office policy memoranda. This summary of pertinent historic factors shall be provided to the case manager, social worker and key community service providers.

[8.371.7.18 NMAC - N, 7/1/2024]

8.371.7.19 ACTIVITY 5: MEETING WITH INDIVIDUAL'S PARENT/GUARDIAN:

A. The case manager shall meet with the individual's parent/guardian to explain the case manager's role and the process by which the individual's placement will be designed and implemented, including the TIDT activities for developing a placement plan, the state's implementation decision described in Activity 19, and the process for resolving disputes. In addition, the case manager shall explain the selection of community service providers, Activities 6 and 7, and make all effort to encourage and expedite this selection, if it has not already occurred, prior to convening any transition meetings.

B. The case manager shall solicit any concerns the parent/guardian might have with any aspect of the transition process of eventual placement in the community. The case manager shall carefully consider and attempt to address those concerns and shall endeavor to reassure the parent/guardian of the authority's commitment to a successful and appropriate placement.

C. The case manager shall provide a copy of the ITP process, 8.371.7 NMAC, individual transition planning process (Appendix A), the dispute resolution process, 8.371.8 NMAC, dispute resolution process (Appendix B) and the case manager's phone number and address to the parent/guardian prior to or at the first meeting with the parent/guardian. The case manager shall encourage the parent/guardian's full participation in the placement process and arrange for interpreter services by coordinating with the *Jackson* transition representative (JTR) and arrange transportation as needed; which shall be paid for by the division, if needed.

D. The case manager shall communicate with the parent/guardian before placement as frequently as necessary (through meetings whenever practical) to keep the parent/guardian informed

and involved in the team process. The information developed for the individual and parent/guardian pursuant to the *Jackson* management manual shall be provided to the individual and parent/guardian.
[8.371.7.19 NMAC - N, 7/1/2024]

8.371.7.20 ACTIVITY 6: DISTRIBUTION OF LIST OF ELIGIBLE COMMUNITY SERVICE PROVIDERS:

A. At the first meeting between the case manager and the individual, and the case manager and the parent/guardian(s), the case manager shall explain the basic community service models, including alternatives to traditional service providers; explain the selection of community service provider(s); and provide the individual and the parent/guardian(s) with a listing of eligible community service provider agencies serving the individual's probable area of relocation. The case manager will encourage a timely selection of community service provider(s).

B. Community service providers could be selected as early as the facility IDT meeting (see above), if the individual and parent/guardian(s) are familiar with community service provider agencies in the area of relocation. Community service providers must be selected no later than 30 days after the parent/guardian(s) initial meeting with the case manager (Activity 5, above). The *Jackson* transition representative (JTR) may supplement the list of eligible community service providers at any time. The *Jackson* transition representative (JTR) shall assist the individual and the parent/guardian with the information necessary for them to make an informed selection. The case manager shall review with the parent/guardian and the individual all possible community service providers in the chosen area of re-location during Activities 3 and 5.
[8.371.7.20 NMAC - N, 7/1/2024]

8.371.7.21 ACTIVITY 7: SELECTION OF COMMUNITY SERVICE PROVIDER(S):

A. The parent/guardian, in consultation with the individual, shall select community service provider(s) to be included in the TIDT and shall notify the case manager of the community service provider selection(s). Community service providers could be selected as early as the facility IDT meeting (see above), if the individual and parent/guardian(s) are familiar with community service provider agencies in the area of relocation. Community service providers must be selected no later than 30 days after the parent/guardian(s) initial meeting with the case manager (Activity 5, above). If the individual's choice of community service provider differs from that of the parent/guardian, the case manager shall arrange for both community service providers to be present at the TIDT meeting if possible. If there is more than one eligible community service provider for a particular service, the parent/guardian may indicate alternate community service provider(s) in order of preference in the event the parent's or guardian's first choice is unavailable to provide the applicable service.

B. The *Jackson* transition representative (JTR) shall confirm community service provider selection within 10 days by contacting the community service provider(s) by telephone and in writing. If the parent/guardian has indicated alternate community service provider(s) in order of preference, the *Jackson* transition representative (JTR) shall document the reason for the unavailability of the higher ranked community service provider before contacting the next ranked provider. If key community service provider(s) are not selected by the parent/guardian and individual, within 49 days of the initial TIDT meeting, the *Jackson* transition representative (JTR) and case manager shall make the selection(s). The *Jackson* transition representative (JTR) shall notify the parent/guardian(s) of the selection, as well as the community service provider(s). Notice of the TIDT meeting as provided in Activity 10 shall be mailed. The TIDT shall review these selection(s) and shall select the non-key provider(s) at its first meeting, if the individual or parent/guardian(s) does not do so.

C. The individual and the parent/guardian should give priority to selecting the community residential provider and other key community service providers within the timelines specified above. The key community service provider(s) shall, either before or at the TIDT meeting, acknowledge that it is able to provide the residential placement or other type of services for which the key service provider(s) shall be brought into the planning process as expeditiously as possible, preferably prior to the TIDT, and shall receive all previous planning and client information.
[8.371.7.21 NMAC - N, 7/1/2024]

8.371.7.22 ACTIVITY 8: WRITTEN INDIVIDUAL PREFERENCE ASSESSMENT: After completing the activities specified above, but at least 26 days before the TIDT meeting described in Activity 11, the case manager shall complete, with the individual and helper, a written assessment of the individual's strengths, interests, likes and dislikes. This assessment shall detail what the individual would like their life to be like in the community, including maintaining existing friendships and building new ones, community involvement, employment for the individual who is an adult, hobbies, leisure activities, and housemates. This assessment and review shall be individualized and rely as much as possible on available community generic resources rather than specialized service models. The case manager will collaborate with the *Jackson* transition representative (JTR) and the facility Q.M.R.P. or social worker to facilitate any co-scheduling of the TIDTs where other class member housemates are identified as a preference.
[8.371.7.22 NMAC - N, 7/1/2024]

8.371.7.23 ACTIVITY 9: WRITTEN COMMUNITY ASSESSMENT: After completing the activities specified above, but

at least 26 days before the TIDT meeting described in Activity 11, the case manager shall prepare a written assessment of the resources and services available in the community or relocation. At the TIDT, this assessment shall be reviewed, in light of the individual's preferences, as assessed under Activity 8, and the identification of the individual's strengths and needs during their daily activities, as identified at the facility annual IPP meeting.
[8.371.7.23 NMAC - N, 7/1/2024]

8.371.7.24 ACTIVITY 10: TIDT MEETING SCHEDULE, NOTICE, AND AGENDA: The *Jackson* transition representative (JTR), shall schedule the full TIDT meeting, which shall be held as promptly as possible after completion of the activities required by Activities 6 and 7. Notice of the date, time and place of the TIDT meeting shall be sent to all participants at least 10 days prior to the meeting. The notice shall also state that participants are to be prepared to address all issues for the individual to ensure a successful transition into a community setting. If any activities required by Activities 6 and 7 occur in less than the maximum time allotted for them by the activity, the *Jackson* transition representative (JTR) shall, whenever possible, proceed to schedule the next required activity (for example, the TIDT meeting required by Activity 11 will be scheduled as promptly as possible after community service providers are selected under Activity 7).
[8.371.7.24 NMAC - N, 7/1/2024]

8.371.7.25 ACTIVITY 11: FULL TIDT MEETING TO DEVELOP THE ITP:

A. The purpose of the TIDT meeting is to develop the individual transition plan (ITP). The ITP is the document developed by TIDT participants identifying the proposed steps to be taken before and after placement and until implementation of a new annual community individual service plan (CISP).

B. The team should attempt to identify or develop services that use the same resources that the general population uses. For instance, the team should make attempts to use or adapt for use local adult education resources instead of looking for a way to set up a special adult education program for individuals who are transitioning.

C. Upon failing to find a generic solution or one that might be adapted, the team should match the preferred specialized solution to the individual's needs and not provide additional services if the need cannot be demonstrated. For instance, if an individual needs staff support only to assist in preparing the evening meal, the team should find ways to deliver that service and no more, rather than developing a residential placement that provides 24 hour staff support because that service is available at the facility.

D. In addition, the TIDT should specify the training and other necessary supports for direct care staff persons who would work directly with the individual in the community setting. Therapeutic and behavioral supports should be delivered primarily through direct care staff persons since they are the most consistently present, interact the most with the individual, and thus know the individual best. Therapists and psychologists should design the individual interventions, train staff to carry them out through the course of the normal daily routine, monitor the program implementation and be available to coach staff and solve problems.

E. The team shall identify each activity in objective form with specific assignment of responsibility and timelines for the accomplishment of each transition activity. For example, a home living provider would be responsible for the accomplishment of home living related tasks, a work/education provider for work/education tasks, and the case manager for monitoring service provision and assuring the presence and preparation of community life and professional services tasks.

F. All team members are encouraged to participate in all areas of the team process, not just in their area or expertise, skill or involvement. Decisions should be made by consensus. Where there is disagreement, the team should continue to work towards a solution that all participants can accept. If consensus is not reached, the team shall make decisions by majority rule. A record shall be maintained of team decisions. The result of the team's effort is the ITP proposed to the division for implementation.

G. The TIDT should attempt to complete the preparation of the ITP in one meeting. Additional TIDT meetings should be scheduled only if the first meeting does not resolve significant issues, such as the identity of the community residential provider or the competitive or supported employment provider, major medical resources or safety issues. For some individuals, planning for the move will be complex and lengthy and may require more than one meeting. For others, addressing the basic requirements of home, work/education, community life and necessary supports will be straightforward and less complex. The case manager, with the concurrence of the TIDT, shall specify in writing the issue(s) necessitating the additional meeting, the identity of the person or entity responsible for addressing and resolving the issue prior to the next meeting, and any other relevant information.

H. Each additional TIDT meeting shall be held within 21 days of the preceding TIDT meeting. The case manager shall mail a copy of the written reasons for the additional meeting to the *Jackson* transition representative (JTR) and shall notify TIDT members of specific tasks and the date of the next TIDT meeting. Absent extraordinary circumstances agreed upon by the TIDT, there shall be no more than two additional TIDT meetings.

I. The TIDT meeting shall be chaired by the case manager. The team shall begin by reviewing the previous assessments

made pursuant to Activities 8 and 9 and the community service provider selections made pursuant to Activity 7. Issues identified and solutions suggested throughout the meeting shall be compared with the assessments to ensure consistency with the individual's preferences where possible.

J. The TIDT shall review and revise the assessments developed in Activities 8 and 9; describe what life should be like for that individual in that community, starting with a discussion of what life is like for other persons of the individual's age and interests and taking into consideration the assessment developed as a result of Activity 9 above; describe those supports that will be needed by the individual; identify the area's generic resources that will be used to provide those supports, or, if generic resources are not readily available, a consideration of those actions that could be taken to enhance existing generic supports for the individual; describe and justify the use of any specialized community service providers. Specialized providers are to be used only when either no generic supports exist or existing generic supports cannot reasonably be enhanced to meet the needs of the individual.

K. TIDT meeting guidelines and agenda: The TIDT shall develop the ITP in accordance with the following guidelines:

(1) The contents of the ITP are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(2) The ITP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable or communicating any preference.

(3) The ITP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible consistent with the individual's needs.

(4) The ITP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs. The ITP can be practically implemented.

L. Life area planning:

(1) The primary task of the TIDT shall be to discuss all issues to be considered for the individual's transition to succeed. This discussion shall include a review of specific items within each of the following "life areas": home environment, vocational, educational, self-care, communication, leisure/social, community resource use, safety, psychological/behavioral/emotional, and medical/health; as well as other pre-placement planning.

(2) The TIDT should review the existing facility IPP objectives related to each of the above "life areas", and identify which objectives are to be continued during the transition period into the community. The TIDT may develop transition objectives to begin at the facility.

M. Supports needed: For each of the life areas discussed, the following general supports should be identified for each relevant transition objective:

(1) human resources needed (volunteers, family, friends/neighbors, paid staff);

(2) assistive technology and adaptive equipment needs listed;

(3) environmental modifications needed / environmental supports described;

(4) transfer and mobility issues identified;

(5) transportation and community access needs identified;

(6) additional support needs identified.

N. Life area discussion items: Life area discussions items include the following (other transition objectives may need to be developed in specific life areas in order to assure a successful transition):

(1) Home environment:

(a) roommate(s) / housemates desired;

(b) location of home identified;

(c) type of home preferred;

(d) orientation to new home;

(e) housing agreements signed, telephone and utilities deposits, and household maintenance;

(f) arrangement for furnishings and households items;

(g) housekeeping skills training required;

(h) food management/ assistance with meals;

(i) respite needs (not applicable for individuals living independently);

(j) banking, financial and budget/ money management;

(k) transfer of personal belongings and description of actual move;

(l) self-management of home and daily routine described.

(2) Vocational:

(a) referral to DVR/NMCB completed;

(b) type of employment or environment preferred;

(c) orientation to new work environment;

(d) assessments needed, vocational training required or training in related skills required.

(3) Educational:

(a) type of educational goal desired;

(b) alternative community based education;

(c) orientation to new school environment.

(4) Self-care:

(a) toileting;

(b)

menses;
(c) dental hygiene;
(d) bathing, grooming and shaving;
(e) dressing and clothing care.
(5) Communication:
(a) method or style individual prefers to use;
(b) communication strengths maintained in new home or communication skills training needed;
(c) speech therapy;
(d) audiology.
(6) Leisure/ social:
(a) opportunities to continue with or increase personal support systems and friends;
(b) opportunities to continue with or increase identified interests and hobbies;
(c) opportunities to continue with or increase family interactions and involvement;
(d) current or desired pets;
(e) sexual education, choices and needs (e.g., relationship or dating skills, AIDS/STD awareness).
(7) Community resource use:
(a) orientation to community and social life, including cultural and ethnic heritages of the community and individual;
(b) religious affiliation;
(c) access to community resources (shopping, laundry, library, post office, etc).
(8) Safety:
(a) safety and hazard awareness training required in home (use of stoves, heaters; emergency use of telephone; poisons, wiring, fire prevention);
(b) safety and hazard awareness training required in community (street safety, dealing with strangers);
(c) alert devices required in home/ community;
(d) identification card or medical alert bracelet/ necklace;
(e) updated medical summary.
(9) Psychological/behavioral/emotional:
(a) development of self-advocacy and decision making skills;
(b) reinforcers and coping mechanisms identified;
(c) psychoactive meds used for emotional or psychiatric purposes;
(d) community psychologist/ psychiatrist identified;
(e) transition or ongoing counseling needs;
(f) behavioral responses to new home;
(g) crisis intervention needs anticipated;
(h) emergency response anticipated;
(i) behavior management plan reviewed.
(10) Medical/ health:
(a) physical condition identified and medical services or appointments needed;
(b) how the individual communicates illness identified;
(c) physician identified and medical records transferred;
(d) physical and occupational therapies;
(e) dental appointments made;
(f) pharmacy identified and prescriptions transferred;
(g) ophthalmologist;
(h) nursing services required;
(i) medication/self-administration;
(j) emergency medical needs anticipated;
(k) hospitalization issues discussed;
(l) nutritionist needed, special diet;
(m) training needs for community medical personnel.
(11) Other pre-placement activities/community IDT planning:
(a) pre-placement visit(s);
(b) cross training activities and community service provider skills development;
(c) specific strategies to provide stability to children not moving to a family home;
(d) guardianship status reviewed;
(e) establish a placement date: The placement date established by the TIDT shall be no later than 228 days after the date of the established initial TIDT meeting.
[8.371.7.25 NMAC - N, 7/1/2024]

8.371.7.26 ACTIVITY 12: DISTRIBUTION OF THE ITP:

A. Within 14 days of the conclusion of the TIDT meeting, the *Jackson* transition representative (JTR) shall produce and distribute the ITP to the case manager, the parent/ guardian, the facility *Jackson* office (for distribution to the facility TIDT members), the community service provider(s), advocate (if appropriate), the division *Jackson* office, other agencies mentioned in the ITP, counsel for plaintiffs, counsel for intervenors (when appropriate).

B. The case manager, after receipt of the ITP, shall meet with the individual, the QMRP and the helper, and review the completed ITP and what it means from the individual's perspective. The case

manager shall assist the parent/guardian by providing information and answering questions concerning the completed ITP and the DRP process.
[8.371.7.26 NMAC - N, 7/1/2024]

8.371.7.27 ACTIVITY 13: COMMUNITY SERVICE PROVIDER CONTRACTS: No later than 30 days after the distribution of the ITP, each community service provider identified in the ITP shall submit, in writing, to the health care authority its cost proposal, including the following information:

A. start up funds required;

B. staff training that will be provided as specified in the ITP, to whom and by when;

C. facility modifications that may be required;

D. provision for administration of medication;

E. any other information as specified by the ITP to be provided in this submission;

F. any other information as specified by the authority.

[8.371.7.27 NMAC - N, 7/1/2024]

8.371.7.28 ACTIVITY 14: PROPOSAL REVIEW: The health care authority shall review the community service provider's proposal and may discuss or clarify any aspect of the proposal with the community service provider. The cost proposals shall be negotiated and approved, according to agreed upon costs, by the division's community programs bureau. The authority shall submit to the community service provider a written notice of the state's intent to fund services for an individual within 30 days of receipt of the community service provider's written proposal. The written notice of intent is not a contract. Unusual costs or specialized services may require an additional two weeks to negotiate and approve. It is incumbent upon the community service providers to submit cost proposals no later than 30 days after the distribution of the ITP.
[8.371.7.28 NMAC - N, 7/1/2024]

8.371.7.29 ACTIVITY 15: COMMUNITY SERVICE PROVIDER / STATE AGREEMENT: Unless delayed because of extraordinary circumstances or an administrative (DRP) or judicial stay order, within 30 days of the community service provider's submittal described in Activity 13 above, providers of service and the health care authority shall negotiate and execute agreements for the delivery of services as specified in the ITP. The medicaid waiver plan of care (POC) shall be approved and submitted to the case manager for signatures. The case manager shall obtain signatures on the completed plan of care, based upon the approved authority cost proposals, at the ITP quality assurance review meeting (Activity 17, below).
[8.371.7.29 NMAC - N, 7/1/2024]

8.371.7.30 ACTIVITY 16: ALTERNATE COMMUNITY SERVICE PROVIDER SELECTION:

A. An ITP quality assurance review meeting shall be held within 30 - 45 days prior to the placement date specified in the ITP. The purpose of this meeting is to assure that the ITP is being successfully implemented, assigned responsibilities have been or are being met and that activities are appropriately accomplished in preparation for the community placement. Participants at the ITPQA review meeting are the same TIDT members, including designated representatives, who were responsible for the development of the ITP. The *Jackson* transition representative (JTR) is responsible for documenting activities at this meeting. Activities occurring at this meeting include:

(1) review of ITP objectives that occur prior to placement and their implementation status;

(2) confirm accomplishment or initiation of tasks by TIDT members;

(3) amendments to the ITP, if required, due to failure to implement objectives or a change in the individual's circumstances;

(4) confirm identity of housemates, staff and others;

(5) confirm cross-over training agenda, participants and schedule with the facility;

(6) describe and plan activities of the actual transition day, including responsible parties and times;

(7) recommend a change in placement date, if required, to assure a successful transition;

(8) finalization of the waiver plan of care: The case manager shall obtain signatures on the completed approved plan of care, based upon the approved cost proposals.

B. The TIDT may review the placement date and recommend a change or extension beyond the 228 day placement requirement; however, changing the originally established placement date requires authorization of the *Jackson* coordinator. Such authorization shall only be given upon evidence of extraordinary circumstances, a judicial stay order or other due process activity.

C. Within two working days following the ITPQA review meeting, the case manager shall submit the completed plan of care with original signatures to the community programs bureau (CPB).

D. In addition to the regularly scheduled ITPQA review meeting, described above, the case manager may, in extraordinary circumstances, reconvene the TIDT, in person or by teleconference if planning activity time lines fall behind schedule, the implementation of the ITP is in jeopardy, or the ITP requires significant modification, such as substitution of a key community service provider. In the case of such reconvened TIDT meetings, the assigned *Jackson* transition representative (JTR) will not attend

the meeting, and the case manager shall be responsible for documenting the amendments to the ITP that are developed. Amendments should be distributed, in a hand-written form, to all TIDT members and designated representatives at the conclusion of the meeting, if xerox capabilities are available.
[8.371.7.30 NMAC - N, 7/1/2024]

8.371.7.31 ACTIVITY 18: DISPUTES: See: Appendix B, Dispute Resolution Process (DRP) for Individual Transition Plans.
[8.371.7.31 NMAC - N, 7/1/2024]

8.371.7.32 ACTIVITY 19: IMPLEMENTATION DECISION BY HEALTH CARE AUTHORITY:

A. Within seven days of the completion of the DRP, if any, the health care authority shall inform the parties to the DRP in writing whether, on the basis of the cost of the individual's ITP or the aggregate costs of individual ITPs, or because the health care authority believes the ITP fails to satisfy constitutional or statutory requirement, it is unable to implement the ITP. If the decision was based on cost, the authority shall not implement the ITP until and unless they have sufficient funds to do so. The authority has the sole discretion to determine whether there are sufficient funds available to implement an ITP. The decision of the authority as to the allocation of funds to ITPs is final and not reviewable. The authority shall engage in good faith efforts to seek the necessary funds through the supplemental and regular budgetary process for the developmental disabilities division of the health care authority and the medicaid DD waiver program and through federal funding which might be available to these programs. Upon appropriation of funding determined by the authority to be sufficient, the TIDT or the community IDT, as appropriate, shall convene to review the final ITP in light of the individual's current circumstances and determine whether any changes should be made.

B. In the event the ITP is not implemented because of cost or because the authority believes the ITP fails to satisfy constitutional or statutory requirements, within 14 days of the completion of the DRP, the authority (with the assistance of its qualified professionals) shall prepare and mail to everyone specified in Activity 12, an interim plan which can be implemented immediately within available resources and which meets constitutional and statutory requirements; or the authority shall immediately request the reconvening of the TIDT and direct the team to develop an interim plan which can be implemented immediately. The interim plan shall be distributed within 14 days of its completion by the reconvened TIDT. Any party eligible to initiate a DRP of the original ITP may initiate a DRP of the interim plan pursuant to Section IV(E) of the DRP. However, the authority's decision regarding the allocation of resources to any ITP or interim plan is within the authority's sole discretion and is not reviewable in the DRP process.

C. If within 20 days of mailing the interim plan no party challenges the plan in a DRP, and the authority approves, the interim plan shall be implemented forthwith.
[8.371.7.32 NMAC - N, 7/1/2024]

8.371.7.33 ACTIVITIES 20 - 23: Activities 20 - 23 shall take place in the time frame specified unless delayed because of the DRP, or extraordinary circumstances.
[8.371.7.33 NMAC - N, 7/1/2024]

8.371.7.34 ACTIVITY 20: IMPLEMENTING THE ITP: TIDT members shall carry out their assigned pre-placement responsibilities. The TIDT is responsible for assuring the completion of placement activities and the readiness of the placement unless delayed pursuant to the policies of Appendix B, Section IV.F., dispute resolution process.
[8.371.7.34 NMAC - N, 7/1/2024]

8.371.7.35 ACTIVITY 21: MONITORING IMPLEMENTATION OF THE ITP: The assigned *Jackson* office representative shall check and document progress twice per month beginning 60 days prior to the placement date on fulfillment of responsibilities assigned in the ITP. If the representative learns of serious implementation problems the *Jackson* office shall direct the case manager to reconvene the TIDT, either in person or through teleconference, to correct the problem.
[8.371.7.35 NMAC - N, 7/1/2024]

8.371.7.36 ACTIVITY 22: REPORTING ON IMPLEMENTATION OF THE ITP: Every other week the division's *Jackson* office representative shall send to TIDT members a report on the status of pre-placement activity. The *Jackson* coordinator shall report specifically on the status of all agreements and community service provider plans of care. Any delay in execution of agreements that may affect other time lines or pre-placement activities shall be identified and strategies for specific action developed and implemented.
[8.371.7.36 NMAC - N, 7/1/2024]

8.371.7.37 ACTIVITY 23: COMMUNITY PLACEMENT: Pre-placement visits with staff and to the new home and work site shall take place as provided in the ITP. Placement shall be accomplished on the date established by the TIDT consistent with the timelines established in Section 13 above.
[8.371.7.37 NMAC - N, 7/1/2024]

8.371.7.38 TRANSITION ACTIVITIES AFTER PLACEMENT:

A. Absent extraordinary circumstances or an administrative (DRP) or judicial stay order, placement shall occur when planned pre-placement ITP activities have been completed. Moving is a stressful experience for anyone. Change in an individual's environment may result in changes in behavior or the need to make

adjustments in program design. Thus, intensive interaction and monitoring shall be necessary immediately following placement. During the two months following placement the following activities shall take place:

(1) Habilitation, treatment and services shall be implemented as provided in the ITP.

(2) During the first week following placement, the case manager shall visit the individual on three of seven calendar days at both the individual's residence and day program with one of the visits occurring in the evening and one occurring on the weekend. The case manager shall observe the implementation of planned services. The case manager, in consultation with the appropriate TIDT member(s) and with the prior approval of the health care authority, may make adjustments in the plan that do not alter the extent of the plan or the frequency, duration or scope of services. Any significant adjustments to the ITP shall be made by the community IDT convened by the case manager as provided in Paragraph (7) below. The case manager shall record the time of the visit, their observations regarding program implementation, and adjustments made to the plan, if any.

(3) During the first month following placement, the community service provider(s) specified in the ITP shall perform assessments as identified and scheduled in the ITP. The direct care staff may collect base line data for the assessments.

(4) During the second through the fourth week following placement, the case manager shall visit the individual at least two times per week.

(5) During the second month following placement the case manager shall visit the individual at least weekly, or more often if required, by the team or the circumstances in order to ensure program implementation in the new environment.

(6) Case managers shall comply with all developmental disabilities division reporting requirements relevant to post-placement activities and reporting.

(7) The case manager should convene and chair the first meeting of the individual's new community IDT (CIDT) within 14 days of placement. The CIDT shall normally consist of the individual (and their chosen representative, if any), the parent/guardian (and their chosen representative, if any), the helper, the case manager, and professional and direct care provider(s). In the absence of any member, the CIDT may proceed with the meeting if appropriate under the circumstances. The team shall meet to:

(a) review program implementation;

(b) provide for any necessary program adjustments;

(c) identify and resolve any problems or potential problems in successful implementation;

(d) determine if assessments are occurring as scheduled pursuant to the ITP; and

(e) schedule the next IDT meeting to develop the community IPP, which shall be developed within 60 days of placement.

(8) The case manager shall convene and chair the second meeting and subsequent meetings of the CIDT to prepare and complete the individual's community individual service plan (ISP). If the current placement plan is an interim plan developed pursuant to Activity 19, in the course of developing the individual's ISP the CIDT shall review the original ITP that was not implemented by the health care authority (see Activity 19) to determine whether any of the components of the original ITP should be incorporated into the ISP. By agreement of the individual, parent/guardian and health care authority or as a result of a decision through a DRP, the ISP shall supersede all previous plans.

(9) Subject to the community DRP and to the principles set forth in Activity 19, the ISP shall be implemented within 60 days following placement. Adjustments to the plan of care or community service provider contracts shall be completed pursuant to the ISP.

B. The goal of the community IDT is to ensure the implementation of the community individual service plan (ISP). In order to do this, the case manager or the case manager's local representative should visit the individual as specified in the ISP or as often as necessary, but no less than two times per month, to assure that the plan is being fully implemented and to assist the individual in becoming a part of their community.

[8.371.7.38 NMAC - N, 7/1/2024]

HISTORY OF 8.371.7 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 371 DEVELOPMENTAL DISABILITIES
PART 8 (APPENDIX B) DISPUTE RESOLUTION PROCESS

8.371.8.1 ISSUING AGENCY: New Mexico Health Care Authority, Developmental Disabilities Division.

[8.371.8.1 NMAC - N, 7/1/2024]

8.371.8.2 SCOPE:

A. This dispute resolution process (DRP) provides for the resolution of disputes concerning the content of or the substantial failure to implement individual program, transition or community plans for class members in *Jackson et al. v. Fort Stanton, et al.,* Civ. No. 87-839 JP.

B. This DRP provides a two-step administrative mechanism for resolving disputes:

(1) a conciliation or mediation stage; and

(2) a review by an independent hearing officer.

C. This process does not allow review by the courts of the decisions of the hearing officers. Any court challenge to any facility, community or other plan or the implementation thereof must be by separate de novo action or by a de novo motion in the *Jackson* case as set forth in Paragraph (9) of Subsection D of 8.371.8.12 NMAC of this DRP.

D. Substantial failure to implement plans shall not include the initial decision by the authority not to implement or approve implementation of the plans because of cost or because of failure to satisfy constitutional or statutory requirements.

[8.371.8.2 NMAC - N, 7/1/2024]

8.371.8.3 STATUTORY AUTHORITY: Subsection E of Section 9-8-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.371.8.3 NMAC - N, 7/1/2024]

8.371.8.4 DURATION: Permanent.

[8.371.8.4 NMAC - N, 7/1/2024]

8.371.8.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.371.8.5 NMAC - N, 7/1/2024]

8.371.8.6 OBJECTIVE:

A. These regulations amend the authority's previously adopted provisions for resolution of disputes arising from the community transition plans of individuals residing at Fort Stanton hospital and training school and Los Lunas hospital and training school. They provide a process for informal resolutions and administrative hearings as well as for suspending the implementation of challenged provisions of an individual's transition or program plan during the time period necessary to allow the dispute to be heard and decided. These amendments reflect the authority's cumulative experience in resolving disputes arising from the transition process.

B. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in *Jackson, et al. v. Fort Stanton, et al.,* N.M. Dist. Ct. No. Civ. No. 87-839. The transition process appearing in these regulations has evolved over time, initially appearing as Appendix B to the *Jackson* management manual and later as authority regulations under the title *Jackson* Dispute Resolution (DRP) process for individual transition plans, Appendix B, HCA 93-1 (DDD). These regulations incorporate certain agreements reached by the parties, including the authority, to the *Jackson* lawsuit.

[8.371.8.6 NMAC - N, 7/1/2024]

8.371.8.7 DEFINITIONS:

A. "Coordinator": The *Jackson* coordinator or the dispute resolution process coordinator or their designees.

B. "Days": Calendar days, except where otherwise specified.

C. "Defendants": The defendants in *Jackson et al. v. Fort Stanton, et al.,* Civ. No. 87-839 JP who are represented by the attorney general. If notice is to be provided to the defendants, it shall be provided to the attorney general.

D. "Division": The developmental disabilities division of the health care authority. If notice is to be provided to the division it shall be provided to the *Jackson* coordinator.

E. "Dispute resolution process coordinator": The developmental disabilities division employee who, under the supervision of the *Jackson* coordinator, is responsible for the coordination and implementation of the dispute resolution process.

F. "Facility": Fort Stanton hospital and training school or Los Lunas center for persons with developmental disabilities.

G. "Helper": Someone who knows the individual's capabilities, interests, likes and dislikes, who communicates with the individual and assists the individual with communication. The helper, if any, is to be chosen by the individual or, if none is chosen by the individual and the individual does not object, by the facility's director of social work or the individual's case manager.

H. "Individual": A person currently residing in Fort Stanton hospital and training school or Los Lunas center for persons with developmental disabilities or a class member who has moved to the community in New Mexico through the ITP process.

I. "Intervenors: The members of the plaintiff-Intervenor-class in *Jackson v. Fort Stanton*, as they may be defined by the court and who are represented by attorneys Kent Winchester and Vernon Salvador.

J. "*Jackson* coordinator": The developmental disabilities division employee who is responsible for various aspects of the division's implementation of the court's orders in *Jackson v. Fort Stanton*.

K. "Parent/ guardian": The court-appointed guardian of an adult individual or the custodial parent(s) if the individual is a minor.

L. "Parties": The individuals and entities identified in Section 9 who may initiate the DRP. As this term is used in subsequent sections of this DRP, it also includes:

(1) The intervenors in their capacity as representative of each parent/guardian of each individual residing in Fort Stanton and Los Lunas who is a member of the plaintiff-intervenor-class, unless the parent/guardian has chosen a representative other than intervenors;

(2) The

plaintiffs in their capacity as representative of each individual residing in Fort Stanton and Los Lunas who is a member of the plaintiff-class, unless the individual has chosen a representative other than plaintiffs;

(3) Any other representative chosen in place of intervenors or plaintiffs; and

(4) The office of the attorney general in its capacity as representative of the authority or the authority's office of general counsel.

(5) If a dispute involves a facility IPP or community ISP, the term "parties" does not include the intervenors or the plaintiffs. Intervenors and plaintiffs may participate in a facility IPP or community ISP dispute only as the representative of an individual or parent/guardian who chooses them to be their representative.

M. **"Plaintiffs":** The members of the plaintiff-class in *Jackson v. Fort Stanton*, as they may be defined by the court in that case, who are represented by protection and advocacy system of New Mexico.

N. **"Plan":** The individualized programs developed by the interdisciplinary team (IDT) including, the facility individual program plan (IPP), the individual transition plan (ITP), the interim plan developed when the authority does not approve the ITP, and the community individual service plan (ISP).

O. **"Team":** The facility interdisciplinary team (FIDT), the transition interdisciplinary team (TIDT) or the community interdisciplinary team (CIDT).

[8.371.8.7 NMAC - N, 7/1/2024]

8.371.8.8 APPLICABILITY:

A. Facility IPP: This DRP may be used for the resolution of disputes concerning the content of or the substantial failure to implement individual program plans for residents of Fort Stanton and Los Lunas hospitals and training schools.

B. Transition planning:

(1) If the dispute involves an individual transition plan (ITP) the DRP may not be invoked until Activity 18 of the "individual transition planning process" (8.371.7 NMAC, hereinafter "ITP Process").

(2) Interim plans: This DRP may be used for the resolution of disputes concerning interim plans developed per Activity 19 of the "individual transition planning process" (8.371.7 NMAC) by the same parties eligible to initiate a dispute concerning the original ITP.

C. Community ISP: This DRP may be used to resolve disputes concerning the content of or the substantial failure to implement *Jackson* class members' ISPs following their placements in the community.

[8.371.8.8 NMAC - N, 7/1/2024]

8.371.8.9 PARTICIPANTS: This DRP may be utilized by: the individual; the individual's parent/guardian; or the authority. The participants may be represented by legal counsel or other representatives.

[8.371.8.9. NMAC - N, 7/1/2024]

8.371.8.10 LIMITATIONS: The state retains the discretion to provide, within current and future resources, individualized plans which may exceed what is required by law. To this end, the DRP provides guidelines for hearing officer decisions in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC that go beyond the requirements of the law. Neither the fact that such guidelines are part of the DRP nor the fact that the state agrees in some cases to provide ITPs or other plans that may exceed the state's legal obligations shall be construed as a waiver of any of the state's legal defenses in any legal proceeding concerning such plans or as an agreement to provide in other cases, plans that exceed what is required by law.

[8.371.8.10 NMAC - N, 7/1/2024]

8.371.8.11 PRELIMINARY MATTERS:

A. Prior to or at the facility IPP or community ISP meeting, the social worker or case manager shall explain the DRP to the individual, the parent/guardian and helper, if any. Prior to or at the initial meeting of the transition interdisciplinary team (TIDT), the case manager shall explain the DRP to the individual, the parent/guardian and helper, if any.

B. Team meetings are intended to be the primary and most effective means of addressing and resolving planning issues. Therefore, all team members are encouraged to participate actively in meetings and in the development of proposed plans.

C. Completed plans shall be distributed as follows:

(1) The completed proposed IPP shall be mailed or delivered, within 30 days of completion, to all team members and to the individual's or the parent's/guardian's chosen representative, if any.

(2) The completed proposed ITP shall be mailed or delivered, within 14 days of completion of the proposed ITP, to all TIDT members, to plaintiffs and to intervenors if the parent/guardian of the individual is an intervenor.

(3) The completed ISP shall be mailed or delivered to all team members and to the individual's or the parent's/guardian's chosen representative within 30 days of the meeting.

D. Although the DRP contains time lines requiring rapid response, such time lines are not intended to reduce the potential for resolving disputes or limiting the involvement of the individual. Thus, for good cause, any person who is responsible for accomplishing a task within a specified time described in 8.371.8.12 NMAC may request a reasonable extension of time from the *Jackson* coordinator or dispute resolution process coordinator, as appropriate. No extensions of time may be granted to accomplish the informal resolution activities described in Subsection B of 8.371.8.12 NMAC. Absent extraordinary circumstances,

extensions of time for the activities described in Subsection C of 8.371.8.12 NMAC shall not exceed 20 days. Grant or denial of a request for an extension of time shall be in writing.

E. Any party initiating the DRP may terminate the process at any time as to the matters raised by that party by withdrawing all pending objections.

F. The DRP is ordinarily intended to be accomplished without the involvement of legal counsel, but the parties may be represented by legal counsel of their choosing at their own expense.

G. Implementation of the plan shall proceed even though there is a DRP in progress except as provided below in Subsection F of 8.371.8.12 NMAC.

H. If the individual has a helper who has participated in a meeting on the individual's behalf, such helper may initiate a facilitated conference or administrative hearing and assist the individual in the DRP only on behalf of the individual and consistent with the wishes of the individual.

I. The plaintiffs, intervenors or other chosen representative of an individual or parent/guardian may initiate a facilitated conference or administrative hearing on behalf of the individual or parent/guardian only if doing so is consistent with the wishes of the individual or the parent/guardian.

J. Notice required to be given to the individual shall also include notice to the individual's helper and representative, if any. Notice required to be given to the parent/guardian shall also include notice to the parent's/guardian's representative, if any. If notice is to be provided to the intervenors, it shall be provided to intervenor's counsel. If notice is to be provided to plaintiffs, it shall be provided to the protection and advocacy system.

K. Any party claiming substantial failure to implement a plan shall request the QMRP or the case manager, as appropriate, to convene a special meeting of the relevant team members prior to initiating the DRP. The meeting shall be held within 10 days.

(1) The team may adopt additional strategies to fully implement the existing plan.

(2) Any actions or additional strategies adopted by the team shall not affect the party's right to initiate a DRP challenging the failure to substantially implement the plan. The time for filing a DRP shall run from the date of the special meeting.

[8.371.8.11 NMAC - N, 7/1/2024]

8.371.8.12 THE PROCESS:

A. Request for facilitated conference: The DRP is initiated by a request for a facilitated conference by any of the parties identified in Section 7 in the capacities specified in that section. The request must be directed to the *Jackson* coordinator or dispute resolution process coordinator and must be received by the coordinator no later than 30 days after the mailing of the completed plan. The request may be made by telephone, in person, or in writing and shall identify any disputed portions of the plan. The coordinator shall record the date of receipt of the request and shall notify the members of the team and the parties of the substance of the dispute. If the request involves an allegation of substantial failure to implement the plan, the request shall be received by the coordinator no later than 30 days after the special team meeting held to address that implementation issue, as provided in Subsection K of 8.371.8.11 NMAC, above. In the event the case manager does not convene the team meeting as requested, or within the time allotted, the DRP must be initiated within 30 days of the request to reconvene the team.

B. Informal resolution: The coordinator shall promptly communicate with the parties and with appropriate team members to determine whether there is a genuine dispute and whether the dispute can be resolved informally without a facilitated conference. If it appears that the dispute can be resolved informally, the coordinator shall attempt to do so. If the dispute is resolved, the coordinator shall notify the members of the team and the parties in writing.

C. Facilitated conference: If the dispute is not resolved informally, the coordinator shall schedule a facilitated conference. The conference shall occur and the resolution or determination shall be distributed within 45 days of receipt of the request for the facilitated conference. The parties shall be notified of the time and location of the conference at least 10 days prior to the conference. The coordinator may request the attendance of team members, professionals, authority personnel or other persons whose presence the coordinator believes could assist in resolving the disputed portions of the plan.

(1) The purpose of the facilitated conference is to resolve the dispute to the extent possible and to agree on any material facts. If the conference participants are unable to resolve the dispute issues to the satisfaction of the party who requested the facilitated conference, the coordinator shall make determinations regarding the disputed issues as follows:

(a) determine that the objection(s) to portion(s) of the plan has merit and either:

(i) amend the plan, accordingly; or

(ii) remand the plan to the team for revision consistent with the coordinator's determination; or

(b) determine that the objection(s) to portions of the plan lacks merit and deny the objection(s); or

(c) determine that implementation of the plan is in substantial compliance with the plan and direct that implementation continue; or

(d)

determine that implementation of the plan is not in substantial compliance with the plan and direct that the plan be implemented appropriately.

(2) The coordinator shall reduce the determination to writing and mail or deliver it to all conference participants and non-participating team members. The written determination shall include the reasons for the determination and recite any amendments to the plan and any agreements as to material facts.

D. Administrative hearing:

(1) Request for hearing: If the party who requested a facilitated conference is dissatisfied with the coordinator's determination, that party may request an administrative hearing to review the determination. If the original dispute issue involved an allegation of a substantial failure to implement and the party making the original request believes that there continues to be a substantial failure to implement, that party may request an administrative hearing. Other parties may request an administrative hearing to review the coordinator's determination only if they participated in the facilitated conference and the coordinator's determination resulted in a change in the contents or implementation schedule of the plan. The request must be made to the developmental disabilities division, Attention: *Jackson* coordinator within 15 days of the date of the coordinator's written determination.

(2) Grounds for hearing: In order for a request to be heard, the party making the request must allege in its request for a hearing that a plan fails to meet at least one of the guidelines set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, as appropriate. The grounds for requesting an administrative hearing are set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, below.

(3) Notice of hearing: The division shall provide written notice of the hearing, the issues raised in the request for hearing and the name of the hearing officer to the parties at least 20 days before the hearing date.

(4) Recusal of hearing officer: If any of the parties has reason to believe that the hearing officer assigned to hear a dispute cannot render a fair and impartial decision, that party shall notify the developmental disabilities division, attention *Jackson* coordinator, of its challenge and the reasons therefore, no later than 10 days from the date of the notice of hearing. If the coordinator determines that there is good cause to recuse the assigned hearing officer, the coordinator shall select another hearing officer within seven days of the date the division received the challenge.

(5) Conduct of hearing:

(a) The authority shall make any team members who are the authority's employees available to testify at a hearing.

(b) The *Jackson* transition representative or another team member will introduce the plan and the coordinator's determination into evidence.

(c) If the contents of a plan are in dispute and the authority is not the objecting party, the authority will go forward to present evidence in support of the plan. If the authority is objecting to the contents of a plan, the party or parties who support the plan will go forward to present evidence in support of the plan.

(d) The party objecting to the contents of the plan will have the burden to prove that the objection has merit and that the plan should be amended in accordance with the objecting party's request.

(e) If a party is alleging that a plan includes a service(s) that is not being provided, that party has the burden to prove that:

(i) The service(s) is not being provided; and

(ii) Such lack of service(s) is a substantial failure to implement the plan.

(6) Evidence:

(a) The hearing officer shall admit all relevant and material evidence, including agreements as to material facts as determined by the Coordinator, that is reasonably likely to assist in the making of a fully informed, fair decision in the dispute. The hearing officer's rulings on evidence are not reviewable. Conformity to legal rules of evidence shall not be necessary.

(b) In all cases the burden of proof shall be established by a preponderance of the evidence.

(7) Guidelines for decisions regarding ITPs and community ISPs: In arriving at a decision, the hearing officer shall utilize the following guidelines in resolving disputed portions of the ITP and community ISP:

(a) The contents of the plan are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(b) The ITP/ISP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable of communicating any preference.

(c) The ITP/ISP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible and consistent with the individual's needs.

(d) The ITP/ISP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

(e) The ITP/ISP can be practicably implemented. Except as provided in Subsection E of 8.371.8.12 NMAC, below, practicality or impracticality is to be determined without regard to cost.

(f)

The plan includes a service or support that is not being provided and the failure to provide such service is a substantial failure to implement the plan.

(8) Guidelines for decisions regarding facility IPPs:

(a) The contents of the IPP are based on professional judgment and are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(b) The IPP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable of communicating any preference.

(c) The IDT considered residential placement, supports, programs, services and activities that would give the individual the opportunity to be more, rather than less, integrated in the community. The IDT's decision to recommend or not to recommend discharge was based upon a consideration of the individual's needs and is consistent with appropriate professional judgment.

(d) The IPP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

(e) The IPP can be practicably implemented. Except as provided in Subsection E of 8.371.8.12 NMAC, below, practicality or impracticality is to be determined without regard to cost.

(f) The plan includes a service or support that is not being provided and the failure to provide such service is a substantial failure to implement the plan.

(9) Decision:

(a) The hearing shall be conducted, and the hearing officer shall render a decision, within 30 days of the *Jackson* coordinator's receipt of the hearing request, or within 30 days of the selection of a new hearing officer if the recusal provisions of Paragraph (4) of Subsection D of 8.371.8.12 NMAC have been invoked. All hearing officer decisions shall contain the following:

(i) The decision on the merits of the dispute; and

(ii) The reasons for the decision, including reference to any guidelines listed in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, as appropriate.

(b) The decision of the hearing officer shall be final as to the plan's compliance with the guidelines set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, as appropriate, of this DRP.

(c) Any challenge in court to any individual plans or the implementation thereof must be by separate *de novo* action or by a *de novo* motion in the *Jackson* case, where appropriate. In any such challenge the DRP and guidelines set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, and in Activity 11 of the individual transition planning process (8.371.7 NMAC) shall not be enforced by the court.

(i) The sole basis for any court challenge to any individualized plan or the implementation thereof shall be that the plan on its face or as implemented does not comply with the individual's rights under constitutional or statutory law. Nothing herein shall be deemed a waiver of any of the state's defenses in the event of such action.

(ii) Statements and evidence presented to the coordinator, the decision of the coordinator, the decision of the hearing officer and the record of any hearing shall not be offered as evidence nor be admissible in any proceeding in court.

(10) Notice of decision: The *Jackson* coordinator shall mail the hearing officer's decision to the parties within three working daysof receipt of the decision.

E. Review of interim plans:

(1) If the authority does not implement an ITP because of cost or because the plan fails to satisfy constitutional or statutory requirements and develops an *interim* plan instead, any party eligible to initiate a DRP of the original plan may initiate a DRP of the interim plan. However, the authority's decision regarding the allocation of resources to any plan or interim plan is final, within the authoritys's sole discretion and not reviewable in the DRP. DRP hearing officers have no authority to order the authority to expend resources beyond those the authority allocates to any plan or interim plan.

(2) All DRP procedures and limitations, including but not limited to those set forth in Subparagraphs (b) and (c) of Paragraph (9) of Subsection D of 8.371.8.12 NMAC, will apply except that if the matter goes to a hearing:

(a) The hearing officer cannot be the person who held the hearing on the original plan, and

(b) The grounds for review and the hearing guidelines are modified and limited to whether the interim plan satisfies the guidelines set forth in Paragraph (8) of Subsection D of 8.371.8.12 NMAC, above, as appropriate, to the extent possible within the resources allocated by the authority to the individual to implement the interim plan.

F. Delays in implementing plans:

(1) Delay of transition process:

(a) During any stage of the DRP, a party may request that some or all ITP implementation activities be delayed pending resolution of the dispute. A request to delay prior to the administrative hearing must be directed to the *Jackson* coordinator. A party may also request a delay in implementation from the hearing officer at the administrative hearing.

(b)

The *Jackson* coordinator or the hearing officer shall order that some or all ITP implementation activities be delayed pending resolution of the dispute if the coordinator or hearing officer determines that:

(i) there are extraordinary circumstances which necessitate delay; or

(ii) the immediate implementation of the ITP would adversely affect the health or safety of the individual.

(c) Delays in implementation pending resolution of a dispute shall be terminated automatically when a dispute is resolved by withdrawal of the dispute, agreement of the parties, failure to request an administrative hearing, or upon the determination by the hearing officer.

(2) Delay of facility or community plans:

(a) The request to initiate a DRP regarding any portion of an IPP or ISP shall automatically delay implementation of the disputed portions unless the health or safety of the individual would be adversely affected.

(b) Delays in implementation pending resolution of a dispute shall be terminated automatically when a dispute is resolved by withdrawal of the dispute, agreement of the parties, failure to request an administrative hearing, or upon the determination.

[8.371.8.12 NMAC - N, 7/1/2024]

HISTORY OF 8.371.8 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 371 DEVELOPMENTAL DISABILITIES
PART 9 ADMISSION, DISCHARGE AND TRANSFER OF ELIGIBLE RECIPIENTS FOR SERVICES IN ICF/MR FACILITIES

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

8.371.9.2 SCOPE:

A. These regulations provide a systematic process for admission of persons requesting services from an intermediate care facility for the mentally retarded (ICF/MR); the transfer between ICF/MR facilities of persons previously determined eligible; and the discharge of persons residing in an ICF/MR.

B. These regulations apply to persons who request admission to an ICF/MR and who reside in the community; in a nursing facility; in a hospital; or, in an ICF/MR. In addition, these regulations apply to any ICF/MR in the state of New Mexico that is licensed under health care authority regulations governing long term care facilities.

C. These regulations are limited to the admission, transfer and discharge of persons receiving support and services funded in whole or in part by state funds or for whom services can reasonably be expected to be funded in whole or in part with state funds within six months of admission into an ICF/MR.

[8.371.9.2 NMAC - N, 7/1/2024]

8.371.9.3 STATUTORY AUTHORITY: Subsection E of Section 9-8-6 NMSA 1978 and Section 28-16A-15 NMSA 1978. 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 purchasing and regulation.
[8.371.9.3 NMAC - N, 7/1/2024]

8.371.9.4 DURATION: Permanent.
[8.371.9.4 NMAC - N, 7/1/2024]

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

8.371.9.6 OBJECTIVE: The purpose of these regulations is to:

A. establish the process for the admission of any and all persons requesting admission to an ICF/MR, to be transferred between ICF/MR facilities, or to be discharged from an ICF/MR;

B. establish admission, transfer and discharge procedures for ICF/MR facilities licensed and located in the state of New Mexico consistent with the Developmental Disabilities Act, Section 28-16A-15 NMSA 1978;

[8.371.9.6 NMAC - N, 7/1/2024]

8.371.9.7 DEFINITIONS:

A. **"Discharge"** means the termination of services for a person previously admitted into an ICF/MR and the discharging facility ceases to be legally responsible for the care of the person.

B. **"Eligible central registry person"** means a person who has requested admission to an ICF/MR, or discharge from an ICF/MR and transfer to a community-based HCA funded program, and who is determined by the HCA to meet pre-admission screening criteria for ICF/MR and home/community-based developmental disabilities services.

C. **"ICF/MR"** means an intermediate care facility that provides food, shelter, health or rehabilitative and active treatment for persons with mental retardation or related conditions, and that has a current license issued by the HCA.

D. **"New admission"** means a person requesting an ICF/MR admission for the first time and does not otherwise qualify as a re-admission. New admissions are subject to pre-admission screening.

E. **"NMSA"** means the New Mexico Statutes Annotated 1978 compilation and all the revisions and compilations thereof.

F. **"Pre-admission screening"** means the evaluation process of the health care authority to determine a person's choice between ICF/MR and community based services, and whether the person has a

developmental disability as described in the *American association on mental retardation's manual on classification in mental retardation (1996)*, or a related condition as defined by 42 CFR 435.1009.

G. "Readmission" means a person re-admitted to an ICF/MR from another type of institution to which they were transferred for the purpose of receiving acute, psychiatric care or rehabilitation following a temporary, acute care episode. A readmission is not subject to pre-admission screening.

H. "Transfer" means movement of an individual from one ICF/MR to another ICF/MR, with or without an intervening hospital stay. A transfer is not subject to pre-admission screening.

I. "State medicaid agency" means the health care authority.

J. "Central registry" means a registry of persons who are requesting or receiving services established by the HCA in accordance with Section 28-16A-15 NMSA 1978.
[8.371.9.7 NMAC - N, 7/1/2024]

8.371.9.8 ADMISSION:

A. No person shall be admitted into an ICF/MR unless the person has been pre-screened and referred to an ICF/MR by the health care authority central registry.

B. Consistent with the provisions of 42 CFR 431.51 any person who requests to be placed on the HCA's central registry will be provided the opportunity to indicate a choice between ICF/MR and home/community-based waiver services at the time of application to the central registry. The purpose of this information request is for system service planning to identify persons who may be potentially eligible for ICF/MR services.

C. All applicants to the central registry may choose to be placed on the central registry for both ICF/MR and home/community-based waiver services.

D. All persons referred for admission into an ICF/MR from the central registry may choose to remain on the central registry for home/community-based waiver services. All persons referred for admission into home/community-based waiver services may choose to remain on the central registry for ICF/MR services.

E. All persons applying to the central registry will be pre-screened by the HCA before placement on the central registry to determine each person's choice between ICF/MR and home/community-based waiver services, and whether the person has a developmental disability or related condition. Pre-screening does not include determination of financial eligibility and level of care, which are functions performed by the state medicaid agency.

F. The HCA will implement application procedures for the central registry that identifies applicant's freedom to choose between ICF/MR and home and community based services.

G. Upon notification from a ICF/MR to the HCA that a vacancy exist in their facility, the HCA will identify three persons from the central registry, in the order of date of application to the central registry, who have indicated a choice for ICF/MR services, and who:

(1) have never been admitted into an ICF/MR; or

(2) were discharged from an ICF/MR for at least 30 days; or

(3) did not qualify as a readmission;

(4) the group of three individuals will be classified as "new admission" for the purposes of these regulations.

H. The HCA will notify the three persons about the availability of a vacancy and request each person to reaffirm in writing their choice between ICF/MR, developmental disabilities home and community waiver services, or other services.

I. The HCA will furnish to an ICF/MR the names and contact information of any persons on the central registry who indicate a choice for ICF/MR services in the long term services division region in which the ICF/MR is located.

J. The ICF/MR will contact and review each person's request for admission in accordance with federal licensing and certification requirements.

K. The ICF/MR will refer any person referred by the central registry, and whom the ICF/MR determined appropriate for admission based on its admission decision, to the state medicaid agency for level of care and financial eligibility determination.

L. The ICF/MR will notify the HCA and the eligible central registry person of the results of its admission decision for all three persons referred by the HCA with an explanation for its decision on each person referred. The ICF/MR will notify any person not admitted of their right to a review of the admission decision.

M. The ICF/MR may admit any person who meets the definition of "readmission" without referral through the HCA's central registry. A readmission will not be subject to pre-screening by the HCA.

N. The health care authority central registry may refer an individual to an ICF/MR vacancy based on the HCA's determination that the referral is an emergency. The HCA may exempt an emergency referral from the central registry to be made based on the person's date of application to the central registry.
[8.371.9.8 NMAC - N, 7/1/2024]

8.371.9.9 TRANSFER:

A. A person may be transferred to another ICF/MR operated by the same entity, or an ICF/MR that operates independent of the ICF/MR where the person currently resides without referral through the central registry, provided:

(1) the person's interdisciplinary team recommends the transfer;

(2) the person's transfer is based on the person's freedom of choice of providers; and

(3) the

receiving ICF/MR has identified a vacancy.

B. An ICF/MR may transfer a person temporarily to a psychiatric acute care hospital, or temporarily to a nursing facility for care following a hospital stay. Persons returning to the ICF/MR under these conditions will be classified a "readmission" and will not be subject to pre-screening by the HCA.

C. Persons receiving services from an ICF/MR may be transferred to a home and community-based waiver program provided the person has been allocated to the program by the HCA in accordance with central registry policies and procedures.

D. The ICF/MR shall provide a complete copy of the person's medical and service records, including assessments required for individual program planning to the ICF/MR or community to which the person is transferred.

[8.371.9.9 NMAC - N, 7/1/2024]

8.371.9.10 DISCHARGE:

A. A person may be discharged from an ICF/MR when the individual/guardian requests to be discharged; when the person's interdisciplinary team recommends the facility cannot meet the individual's needs; the individual no longer requires an active treatment program in an ICF/MR setting; the discharge would be more beneficial to the person; or for any other good cause. Any decision to discharge a person from an ICF/MR based on good cause must be adequately justified in writing by the ICF/MR and reviewed by the HCA prior to discharge.

B. The ICF/MR will ensure the person's family/guardian and the person's advocate is involved in the interdisciplinary team process, involving a discussion and proposed decision regarding discharge.

C. The ICF/MR will ensure a transition plan is developed 30 working days prior to discharge in accordance with HCA policies on discharge and transition of persons in services.

D. The ICF/MR will ensure the person and their guardian are fully informed of their right to a fair hearing in accordance with 42 CFR 431.200-431.250.

E. The ICF/MR will ensure any discharge decision is carried out in accordance with provisions of 42 CFR 456.380.

[8.371.9.10 NMAC - N, 7/1/2024]

8.371.9.11 NOTIFICATION OF THE HCA:

A. The ICF/MR will notify the HCA of any vacancy or anticipated vacancy in their facility.

B. The ICF/MR will notify the HCA of any person requesting ICF/MR services and for whom state funding may be necessary.

C. The HCA will notify an ICF/MR of any person on the central registry indicating a choice of ICF/MR services in the long term services division region in which the ICF/MR is located.

D. Notice by either party shall be based on timelines adopted by the HCA.

[8.371.9.11 NMAC - N, 7/1/2024]

HISTORY OF 8.371.9 NMAC: [**RESERVED**]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 372 INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
PART 1 GENERAL PROVISIONS

8.372.1.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.372.1.1 NMAC - N, 7/1/2024]

8.372.1.2 SCOPE: This rule applies to the general public.

[8.372.1.2 NMAC - N, 7/1/2024]

8.372.1.3 STATUTORY AUTHORITY: Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority (HCA). The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.372.1.3 NMAC - N, 7/1/2024]

8.372.1.4 DURATION: Permanent.

[8.372.1.4 NMAC - N, 7/1/2024]

8.372.1.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.372.1.5 NMAC - N, 7/1/2024]

8.372.1.6 OBJECTIVE: The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.

[8.372.1.6 NMAC - N, 7/1/2024]

8.372.1.7 DEFINITIONS: This section contains the glossary for the New Mexico behavioral health system. The following definitions apply to terms used in this chapter and shall guide any rules promulgated by collaborative members regarding

behavioral health.

A. Definitions beginning with letter "A":

(1) Abuse, individual: Any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with 30-47-1 NMSA 1978.

(2) Abuse, provider: Provider practices that are inconsistent with sound fiscal, business, medical or service related practices and result in an unnecessary cost to the program, or in reimbursement for services that are not medically, clinically, or psychosocially necessary or in services that fail to meet professionally recognized standards for behavioral health care.

(3) Adult behavioral health procedures manual: The procedures manual that includes the psychiatric rehabilitation program requirements and comprehensive community support services requirements.

(4) Advance directive: Written instructions such as a mental healthcare advance directive, psychiatric advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive, relating to the provision of health care when an adult is incapacitated. (See generally, Sections 27-7A-1 - 27-7A-18 NMSA, 1978, and Section 24-7B-1 - 24-7B-16 NMSA 1978.)

(5) Adverse determination: A determination by the BHE that the behavioral health services furnished, or proposed to be furnished to a consumer, are not medically, clinically or psychosocially necessary or not appropriate.

(6) American society of addiction medicine (ASAM): An organization of professionals in addiction services that developed, in the early 1990s, a set of criteria and tools to identify the level of care best suited to an individual in need of addiction services.

B. Definitions beginning with letter "B":

(1) Behavioral health (BH): The umbrella term for mental health and substance abuse. It includes both mental health (MH), including psychiatric illnesses and emotional disorders, and substance abuse (SA), including addictive and chemical dependency disorders, and includes co-occurring MH and SA disorders and the prevention of those disorders.

(2) Behavioral health entity (BHE): One or more managed care organizations selected by HSD and the collaborative to provide all defined behavioral health service responsibilities, including medicaid behavioral health.

(3) Behavioral health planning council (BHPC): The body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico, and with which the BHE will be expected to interact with as an advisory council. (See Section 24-1-28 NMSA, 1978)

C. Definitions beginning with letter "C":

(1) Chair or co-chairs: The secretary of the health care authority shall serve as the chair of the collaborative. The secretary of health and the secretary of children youth and families shall alternate each state fiscal year as the co-chair of the collaborative.

(2) Clinical necessity: The determination made by a behavioral health professional exercising prudent clinical judgment as to whether a behavioral health service would promote growth and development, prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a behavioral health condition, injury, or disability for the consumer.

(3) Collaborative: The interagency behavioral health purchasing collaborative, responsible for planning, designing and directing a statewide behavioral health system. The collaborative, established under Section 9-7-6.4 NMSA 1978, by its statutory member agencies collectively, operates under by-laws adopted by the collaborative.

(4) Collaborative members or member agencies: The statutory and *ex officio* agency representatives who sit on the collaborative or their agency designees.

(5) Comprehensive community support services (CCSS): CCSS is a recovery and resiliency oriented service which is provided in the community, primarily face-to-face, using natural supports to the maximum extent possible to build on client and family strengths. These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a consumer or member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community. (See, 8.315.6 NMAC, 8.305.1 NMAC and collaborative adult behavioral health procedural manual.)

(6) Consumer: For purposes of these rules, a person with a mental health or substance use disorder receiving or eligible to receive behavioral health services through collaborative or collaborative member contracts, or a past recipient of such services.

(7) Consumer empowerment: Activities that address the following areas:

(a) consumer choice

(b) consumer voice

(c) self-management

(d) community integration

(8)

Continuous quality improvement (CQI): CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

(9) Core service agencies (CSAs): Multi-service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for consumers with complex behavioral health service needs, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.

(10) Credentialing: A systematic process whereby the BHE or provider verifies and warrants that an employed, contracted or affiliated behavioral health professional or agency meets specified practice standards including education, experience, licensure and certification.

(11) Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural situations, including situations of diverse culture, race, ethnicity, national origin or disability. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. *See*, 8.305.1.7 NMAC.

D. Definitions beginning with letter "D":

(1) Delegation: A formal process by which a BHE gives another entity the authority to perform certain functions on its behalf but for which the BHE retains full accountability for the delegated functions.

(2) Designated representative: A person designated under a valid mental health care treatment advance directive as an individual's authorized agent according to the provisions of the Mental Health Care Treatment Decisions Act (Subsection B of Section 24-7 NMSA 1978) and who has personal knowledge of the respondent and the facts as required in Subsection B of the act.

E. Definitions beginning with letter "E":

(1) EPSDT: Early and periodic screening, diagnostic and treatment.

(2) Ex-officio members: Non-voting members of the collaborative, who otherwise serve as full members (e.g. the secretary of higher education department, secretary of veteran's services department, New Mexico public defender, and the children's cabinet coordinator).

(3) Executive committee: A committee of the collaborative comprised of the secretaries of the health care authority, health, and children youth and families. The executive committee is authorized to negotiate, approve and execute contracts and amendments on behalf of the collaborative.

F. Definitions beginning with letter "F":

(1) Family-centered care: When a child is the consumer, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and behavioral health professionals, builds on individual and family strengths and respects diversity of families.

(2) Family specialist: An approved provider who is certified as a family specialist through an approved state certification program. (See Subsection U of 7.20.11.7 NMAC)

G. Definitions beginning with letter "G":

(1) Grievance (consumer): Oral or written statement by a member expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

(2) Grievance (provider): Oral or written statement by a provider to the BHE expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

H. Definitions beginning with letter "H": **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

I. Definitions beginning with letter "I": Indicated prevention: Interventions that identify individuals who are experiencing early signs of substance abuse, mental illness and other related problem behavior and target them with special programs.

J. Definitions beginning with letter "J": [RESERVED]

K. Definitions beginning with letter "K": [RESERVED]

L. Definitions beginning with letter "L":

(1) Letter of direction (LD): Written instructions, detailed action steps, and guidelines to clarify the implementation of programs funded by new funding sources or changes to programs funded by funding sources identified in the BHE contract.

(2) Local collaborative (LC): An advisory body, delineated by either judicial district or tribal grouping and recognized by the collaborative, that provides input on local and regional behavioral health issues to the collaborative, the BHPC and the BHE.

(3) Logic model, prevention services: A logical conceptual framework used to connect the prevention effort with its intended results and the goal

of reducing substance abuse. The framework is based upon existing knowledge that is refined or revised with new research. The logic model specifically describes the changes expected within the target population(s), why it is likely that these changes would result from the proposed prevention services and activities, and how this logically relates to the needs assessment.

M. Definitions beginning with letter "M":

(1) Managed care organization (MCO): An organization that contracts with the state of New Mexico to provide a variety of health care services to individuals who are enrolled.

(2) Management letter: A document signed by the co-chairs of the collaborative and a representative of the BHE authorized to bind the BHE that describes a certain task or activity to be pursued or conducted by the BHE, the specific approach to that task or activity, the expected result and the schedule to be followed to implement the task or activity. Such letters are not intended to be amendments to the BHE contract, but more specific directions for completing contract requirements.

(3) Medicaid: The medical assistance program authorized under Title XIX and Title XXI of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(4) Medically necessary services: Clinical and rehabilitative physical, mental or behavioral health services that:

(a) are essential to prevent, diagnose or treat medical or behavioral health conditions or are essential to enable the consumer to attain, maintain or regain the consumer's optimal functional capacity;

(b) are delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the consumer;

(c) are provided within professionally accepted standards of practice and national guidelines; and

(d) are required to meet the physical, mental and behavioral health needs of the consumer and are not primarily for the convenience of the consumer, the provider or the BHE. (Subparagraphs (a) and (b) of Paragraph (7) of Subsection M of 8.305.1.7 NMAC)

N. Definitions beginning with letter "N":

(1) Network provider: An individual provider, clinic, group, association or facility employed by or contracted with a BHE to furnish covered behavioral health services to consumers under the provisions of the BHE contract.

(2) Non-network provider: An individual provider, clinic, group, association or facility that provides covered services and does not have a contract with the BHE.

O. Definitions beginning with letter "O": [RESERVED]

P. Definitions beginning with letter "P":

(1) Peer specialist: An approved provider who is certified as a peer specialist through a state approved certification program. (Paragraph (4) of Subsection A of 8.315.6.10 NMAC)

(2) Performance measures: A system of operational and tracking indicators specified by state or federal requirements or the collaborative, including but not limited to the federal national outcome measures (NOMS).

(3) Prevention services: Services that follow current national standards for prevention including both physical and behavioral health.

(4) Prevention provider: A provider under contract for the exclusive or primary purpose of providing services designed to prevent or reduce the prevalence of substance abuse, mental illness, or other specified behavioral health disorders.

(5) Psychosocial necessity: Services or products provided to a consumer with the goal of helping that individual develop to their fullest capacities through learning and environmental supports and reduce the risk of the consumer developing a behavioral health disorder or an increase in the severity of behavioral health symptoms. The consumer need not have a behavioral health diagnosis but rather have a need to improve psychosocial functioning.

Q. Definitions beginning with letter "Q": [RESERVED]

R. Definitions beginning with letter "R":

(1) Recovery: Behavioral health recovery is an individual's personal journey of healing and transformation enabling a person with a behavioral health problem to live a meaningful life in a community of their choice while striving to achieve their full potential.

(2) Re-credentialing: A systematic process whereby the BHE verifies and warrants that an employed or affiliated behavioral health professional who is currently credentialed, continues to meet specified practice standards, including education, experience, licensure and certification.

(3) Resiliency: A global term describing a dynamic process, whereby people overcome adversity and go on with their lives in a productive and self-satisfying manner.

(4) Responsible offeror: An offeror who submits a response proposal and who has furnished, when required, information and data to prove that the offeror's financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property described in the proposal.

S. Definitions

beginning with letter "S":

(1) Selective prevention: Prevention interventions targeted at a subgroup of the general population that is determined to be at risk for sexual assault, substance abuse or mental illness.

(2) State: The state of New Mexico, including any entity or agency of the state and including but not limited to the collaborative and member agencies.

(3) Subcontract: A written agreement between the BHE and a third party, or between a subcontractor and another subcontractor, to provide services, and where appropriate approved by the collaborative.

(4) Subcontractor: A third party who contracts with the BHE or a BHE subcontractor for the provision of services.

(5) Supported employment: Integrated work for not less than the federal minimum wage in a setting with ongoing support services for individuals with severe disabilities for whom competitive employment:

(a) has not traditionally occurred;

(b) has been interrupted or intermittent as a result of severe disability, and who,

(c) because of the nature and severity of their disabilities need intensive physical, educational, social or psychological support to perform work.

(6) Supportive housing: Permanent housing that is affordable to individuals with low or no incomes, is chosen by the individual, which a person retains even if their service needs change, and which is an essential ingredient to foster and support a person's journey towards recovery and resiliency.

T. Definitions beginning with letter "T": [RESERVED]

U. Definitions beginning with letter "U": Universal prevention: Prevention interventions intended to reach the entire population or a large share of it, without regard to individual risk factors.

V. Definitions beginning with letter "V": [RESERVED]

W. Definitions beginning with letter "W": [RESERVED]

X. Definitions beginning with letter "X": [RESERVED]

Y. Definitions beginning with letter "Y": [RESERVED]

Z. Definitions beginning with letter "Z": [RESERVED]

[8.372.1.7 NMAC - N, 7/1/2024]

8.372.1.8 MISSION STATEMENT: The mission of the collaborative is to ensure that quality behavioral health services are provided to both medicaid and non-medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a single service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[8.372.1.8 NMAC - N, 7/1/2024]

HISTORY OF 8.372.1 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 372 INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
PART 2 STANDARDS OF DELIVERY FOR BEHAVIORAL HEALTH SERVICES

8.372.2.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.372.2.1 NMAC - N, 7/1/2024]

8.372.2.2 SCOPE: This rule applies to the general public.

[8.372.2.2 NMAC - N, 7/1/2024]

8.372.2.3 STATUTORY AUTHORITY: Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority (HCA). The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.372.2.3 NMAC - N, 7/1/2024]

8.372.2.4 DURATION: Permanent.

[8.372.2.4 NMAC - N, 7/1/2024]

8.372.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.372.2.5 NMAC - N, 7/1/2024]

8.372.2.6 OBJECTIVE: The objective of this rule is to provide

policies for the standard of delivery for behavioral health services through contracted behavioral health entities.
[8.372.2.6 NMAC - N, 7/1/2024]

8.372.2.7 DEFINITIONS: [RESERVED]
[8.372.2.7 NMAC - N, 7/1/2024]

8.372.2.8 MISSION STATEMENT: The mission of the interagency behavioral health collaborative (the collaborative) is to ensure quality behavioral health services are provided to medicaid and non-medicaid consumers; providers are reimbursed timely and accurately; data is collected, and services promote prevention, recovery, resilience, and efficient use of available resources. This mission serves the collaborative vision to establish a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.
[8.372.2.8 NMAC - N, 7/1/2024]

8.372.2.9 QUALITY MANAGEMENT: The collaborative recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner with better outcomes for consumers and families. Under the terms of the interagency behavioral health collaborative contracts, quality assurance and management programs are incorporated into behavioral health care delivery and administrative systems.
[8.372.2.9 NMAC - N, 7/1/2024]

8.372.2.10 BROAD STANDARDS:

A. Commitment to persons served: The behavioral health entity (BHE) and provider shall provide or ensure that:

(1) service delivery is individually centered and family-centered, and furthers an individual's capacity for recovery and resiliency;

(2) all services are designed to enhance, promote and expand the recovery, resiliency, independence, self-sufficiency, self-esteem and quality of life of the persons served;

(3) individuals served are involved in the individual planning, decision-making, implementation and evaluation of services provided;

(4) agents under an advance directive, family members, guardians or treatment guardians, caregivers, or other persons critical to the consumer's life and well-being are involved in the individual planning, decision-making, implementation and evaluation of services provided, subject to requirements or principles of confidentiality and individual choice;

(5) the system offers a full range of appropriate behavioral health services for multi-diagnosed clients, including facilitating access to and coordinating care with appropriate medical care providers;

(6) services are based on evidence of effectiveness;

(7) services consider the individual consumer's and family's preferences;

(8) services and providers comply with Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

B. Collaboration and system of care requirements: The BHE shall be responsible for developing a system of care that offers acceptable access and appropriate, effective care to all individuals and families served. The BHE shall coordinate and collaborate with the collaborative in the implementation of the requirements of this or other rules and the requirements of any contracts between the BHE and the collaborative. The BHE shall work with the BHPC and, upon request, with LCs to seek advice and comment during the planning, implementation, and evaluation of services. The BHE shall consult with the BHPC to identify service gaps and needs, including provider training, coaching and supervision needs and opportunities.

C. Reporting requirements: The BHE shall provide to the collaborative such reports as may be required by the BHE contract. The BHE shall verify the accuracy and completeness of data and other information in reports submitted.

D. Behavioral health data: For reporting purposes, behavioral health data shall be collected and reported as required by contract for any consumer or family member receiving any behavioral health service provided by a behavioral health practitioner, regardless of setting or location as required by the collaborative, including behavioral health licensed professionals, practicing within the BHE. The BHE shall monitor and ensure the integrity of data. Findings shall be reported to the collaborative as required by the BHE contract.

E. Emergency response requirements: The BHE shall participate in disaster behavioral health planning and emergency response with the collaborative and in a manner consistent with the protocol of described in the New Mexico department of health emergency operations plan, psychosocial annex. The BHE shall ensure that its network providers are likewise prepared to be responsive and appropriate to the specific needs of an event calling for emergency response and psychosocial support services.

F. Sexual assault: The BHE shall ensure that its providers have the capacity to provide comprehensive, confidential and sensitive services to victims of sexual assault as mandate by the Sexual Crimes and Prosecution and Treatment Act, Sections 29-11-1 through 29-11-7, NMSA 1978.

G. Advance directives: The BHE shall have and implement policies and procedures for advance directives. The BHE shall require its providers to honor advance directives within its utilization management protocols.

H. Forensic evaluations: The BHE shall ensure that network and non-network providers providing forensic evaluations shall assure that such evaluations shall be performed pursuant to court authority and either the *Rules of Criminal Procedure for the District Courts,* 5-602.B, NMSA 1978, or other legal authority. Each evaluation file shall have a copy of the court order from the state district court.

I. Special coordination requirements: The BHE shall ensure effective coordination with other service systems and providers. Such coordination shall include at least the following:

(1) physical and behavioral health services;

(2) emergency services;

(3) pharmacy services;

(4) transportation;

(5) supportive housing;

(6) SCI MCOs;

(7) CYFD, including children in CYFD custody;

(8) New Mexico corrections department;

(9) court-ordered or parole board-ordered treatment;

(10) children in tribal custody or under tribal supervision;

(11) adolescents transitioning into the adult system;

(12) children with IEPs;

(13) medicaid eligibility outreach and assistance;

(14) medicaid waiver and non-medicaid disability programs;

(15) aging and long-term services department programs;

(16) HIV/AIDS treatment providers;

(17) individuals with special health care needs;

(18) supported employment.

J. The BHE shall ensure that consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders, receive covered services in a manner that meets their unique needs and in accordance with the specific requirements of the BHE contract.

K. The BHE shall comply with all applicable standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments.

L. The BHE shall hold subcontractors to all standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments and shall monitor and assure compliance. Subcontracts of the BHE shall allow the BHE to observe or review administrative or clinical practices for contract compliance, quality management and outcomes.

[8.372.2.10 NMAC - N, 7/1/2024]

8.372.2.11 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. Program structure and operations: Quality management is an integrated approach that links knowledge, structure and processes together throughout a BHE's system to assess and improve quality. The BHE's quality management (QM) and improvement (QI) structures and processes shall be planned, systematic, clearly defined, and in full compliance with the BHE contract. The BHE shall comply with the provisions of 8.305.8.12 NMAC, regardless of the funding source of services. The BHE shall ensure that the QM/QI program is applied to the entire range of covered services and all major demographic population groups in accordance with the BHE contract. The BHE shall have an annual QM/QI work plan, prior approved by the collaborative, and as specified in its BHE contact with the collaborative.

B. Continuous quality improvement/total quality management: The BHE shall base its administrative operations and service delivery on principles of continuous quality improvement/total quality management (QM/QI). Such an approach shall include at least the following:

(1) recognize that opportunities for improvement are unlimited;

(2) ensure that the QM/QI process shall be data driven;

(3) require the continual measurement of clinical and non-clinical effectiveness and programmatic improvements of clinical and non-clinical processes driven by such measurements;

(4) require the re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and

(5) rely on consumer and stakeholder input.

C. Prevention and coordination of care: The BHE shall institute QM/QI policies and procedures that emphasize and promote prevention and coordination across multiple providers and systems.

D. Consumer/family satisfaction: The BHE shall work with the collaborative in conducting the annual adult and child/family consumer satisfaction survey based on the national mental health statistics improvement project or successor projects. If the BHE conducts any other or separate satisfaction survey, such survey, including the survey instrument and methodology, shall be prior approved by the collaborative. The BHE shall comply with requirements of 8.305.8.11 NMAC

and such other requirements as the BHE contract may require.

E. Clinical practice guidelines: The BHE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of services for acute and chronic behavioral health care conditions.

(1) The BHE shall select the clinical issues to be addressed with clinical guidelines based on the needs of consumers.

(2) The clinical practice guidelines shall be evidence-based.

(3) The BHE shall comply with the provisions of 8.305.8.12 NMAC regardless of the funding source for services. The BHE shall fully comply with all specifications of the BHE contract regarding clinical practice guidelines and evidence-based practices.

[8.372.2.11 NMAC - N, 7/1/2024]

8.372.2.12 PERFORMANCE MEASURES:

A. BHE shall be accountable as specified in its contract for the achievement of any performance measure targets identified by the collaborative. The BHE shall measure and track performance measures, report on such measures at intervals defined by the collaborative, and incorporate performance measures as part of its QM/QI program. Performance measures include those required by the federal government or specified by the collaborative.

B. Effectiveness of the QI program: The BHE shall evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and non-clinical service to consumers. The BHE shall conduct data-driven evaluations of clinical practices to improve quality of care. The BHE shall demonstrate how it has influenced or changed provider practice patterns.

[8.372.2.12 NMAC - N, 7/1/2024]

8.372.2.13 STANDARDS FOR UTILIZATION MANAGEMENT: The collaborative requires appropriate utilization management (UM) standards to be implemented as well as activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under-utilization. The BHE shall manage the use of resources, maximize the effectiveness of care by evaluating clinical appropriateness, and authorize the type and volume of services through fair, consistent and culturally competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes. The consumer's service plan or treatment plan priorities, advance directives, and prolonged service authorizations for individuals with chronic conditions shall be considered in the decision-making process.

A. Necessity requirement: The BHE shall comply with 8.305.8.13 NMAC regarding standards for utilization management. References to "medical necessity" in 8.305.8.13 NMAC shall be read as "clinical and psychosocial necessity" as defined in these rules. References to "member" in 8.305.8.13 NMAC shall be read as "consumer" and shall include the consumer's family, legal guardian, and designated representative as appropriate. All requirements in 8.305.8.13 NMAC regarding providing notice to providers shall include notice to the consumer and consumer's family, legal guardian, and designated representative as appropriate.

B. Use of qualified professionals: The BHE shall ensure the involvement of representative practicing providers, consumers and family members in the development of its UM procedures. The BHE shall evaluate network provider satisfaction with the UM process as part of its annual provider satisfaction survey.

C. Decisions: The BHE shall make available UM decision criteria to providers, consumers, their families, and the public. The BHE shall ensure that consumers have an optimal choice of providers consistent with their treatment needs and available providers.

D. Records: The BHE shall maintain records (both hard and electronic) that verify its utilization management activities and compliance with UM requirements specified in this rule and the specific contractual requirements of the BHE contract.

[8.372.2.13 NMAC - N, 7/1/2024]

8.372.2.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The BHE shall have and implement policies and procedures that comply with 8.305.8.14 NMAC, as well as any other applicable credentialing or recredentialing requirements from collaborative member departments and agencies, including but not limited to any federal block grant or other collaborative practice protocols, rules or other requirements.

A. Practitioner participation: The BHE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. Credentialing application: The BHE shall use a collaborative-approved application for network participation.

C. Evaluation of practitioner site: The BHE shall perform an initial visit to the offices of potential high volume behavioral health care providers, as determined by the BHE with approval of the collaborative.

D. Assessment of organizational providers: For organizational providers, the BHE shall confirm that the provider is in good standing with state and federal regulatory bodies and has been certified by the appropriate state certification agency, when applicable.

E. Performance evaluation: The BHE shall ensure that all providers maintain the certification and training necessary to provide the services they offer. The BHE shall utilize QM/QI data in conducting provider recredentialing,

recontracting or performance evaluations.

F. Practices and programs: The BHE shall ensure that credentialing and recredentialing requirements shall recognize and promote approaches to services such as consumer- and family-run programs, Native American healing practices and programs, traditional curanderismo, and other legally acceptable programs.
[8.372.2.14 NMAC - N, 7/1/2024]

8.372.2.15 RIGHTS AND RESPONSIBILITIES: The BHE and the provider shall have a written policy, approved by the collaborative as required, that states their commitment to treating clients in a manner that respects their rights, respecting and recognizing the consumer's dignity and need for privacy. This policy shall also address the BHE and the provider's expectations with regard to clients' responsibilities. The BHE shall comply with 8.305.12 NMAC and 8.349.2 NMAC regarding grievances and appeals, regardless of funding source. The BHE shall be required to comply with NMAC 8.305.8.15 NMAC, member (consumer) bill of rights, any other collaborative member department or agency's rights' statements, and all consumer rights and responsibilities provisions of the BHE contract with the collaborative.

A. Consumer handbook: The BHE shall maintain a consumer handbook, prior approved by the collaborative, that includes but is not limited to information about consumer rights and responsibilities. The written information provided to consumers or clients of the BHE or provider shall be comprehensible, readable, easily understood and culturally sensitive.

B. Complaints or grievances:

(1) Consumers, their families or legal guardians, and designated representatives have a right and shall have the means to voice complaints or file grievances and appeals about the care provided by the BHE or provider in its network.

(2) The BHE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals.

(3) The BHE and the provider shall have written policies and procedures for the timely resolution of client or provider complaints or grievances.

(4) The BHE shall provide information specified in 42 CFR Section 438.10(g)(1) about its grievance system to all providers and subcontractors at the time they enter a contract.

(5) The BHE shall provide the collaborative regular reporting of all consumer and provider grievances, appeals, and fair hearings, and such other related data and information as specified in the BHE contract.
[8.372.2.15 NMAC - N, 7/1/2024]

8.372.2.16 STANDARDS FOR CLINICAL RECORDS:

A. Standards and policies: The BHE shall require clinical records to be maintained in a format and manner that is timely, legible, current, and organized, and that permits effective and confidential consumer care and quality review. The BHE shall fully comply with all medical records, data, and confidentiality requirements of the BHE contract and any relevant state and federal law.

B. Confidentiality: The BHE shall have and implement clinical record confidentiality policies and procedures that implement the requirements of state and federal law and policy, this rule, and the BHE contract. These policies and procedures shall be consistent with confidentiality requirements in 45 CFR parts 160 and 164 for all medical records and any other health and enrollment information that identifies a particular consumer. Medical record contents shall be consistent with the utilization control required in 42 CFR Part 456, 42 CFR 431.305(b) and 45 CFR 164.530(c).

C. Evaluation and treatment or service records:

(1) To promote effective service delivery and quality review, treatment or service records shall be maintained in a manner that is current, comprehensive, detailed, organized, and legible.

(2) The BHE and the provider shall ensure that consumers and family members participate in treatment or service planning, development, and implementation and maximize consumer and family recovery and resiliency. The BHE shall ensure that consumers and family members, where appropriate, are presented with opportunities to proactively engage and participate in the behavioral health service delivery system, with a focus on the family as a potential change agent where consistent with the consumer's preferences and wishes.
[8.372.2.16 NMAC - N, 7/1/2024]

8.372.2.17 STANDARDS FOR ACCESS:

A. Ensure access: The BHE shall ensure the accessibility and availability of behavioral health providers for each medically, clinically or psychosocially necessary service. The BHE shall comply with 8.305.8.18 NMAC, regardless of the funding source and shall comply with such geo-access standards as the collaborative may require. The BHE shall maintain and update its service access plan, which shall describe the BHE's system for consumer access to services.

B. Array of services: The BHE shall ensure that in each region of the state there is an array of covered services that allow consumers to be served within the least restrictive setting and in close proximity to their places of residence, with preference given to in-state providers.

C. Appointment standards: The BHE shall ensure that appointment standards detailed in the BHE contract are met by the provider and shall report to the collaborative on the compliance of providers in meeting appointment standards.

D. Access to

transportation services: The BHE shall assist consumers in accessing existing transportation benefits and resources to provide transportation to covered services, including transportation to address a behavioral health issue during non-business hours and transportation related to an emergency. The BHE shall coordinate behavioral health transportation services with the consumer's respective MCO, where applicable.

E. Cultural competency: The BHE and provider shall provide effective services to people of all cultures, races, ethnic backgrounds, religions in a manner that respects the worth of the individual and protects the dignity of each individual regardless of the circumstances under which services are sought.

(1) The BHE shall develop, implement, evaluate, and update a cultural competency plan for itself and for all network providers to ensure that consumers and their families, including individuals with disabilities, receive covered services that are culturally and linguistically appropriate to meet their needs.

(2) The BHE shall ensure that providers have access to specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. The BHE shall ensure compliance with 8.305.1.7 NMAC, regardless of funding source.

[8.372.2.17 NMAC - N, 7/1/2024]

8.372.2.18 DELEGATION: Delegation is a process whereby the BHE gives another entity the authority to perform certain functions on its behalf. The BHE shall be fully accountable for the quality of clinical care and services provided to consumers through its delivery system. The BHE may not delegate the accountability for the quality of services provided. The BHE will be responsible for the QM/QI program and not delegate this responsibility to subcontractors. The BHE shall not assign, transfer or delegate key management functions such as utilization review/utilization management or care coordination without the explicit written approval of the collaborative. The BHE shall ensure its full compliance with all delegation requirements of the BHE contract.

[8.372.2.18 NMAC - N, 7/1/2024]

HISTORY OF 8.372.2 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 372 INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
PART 3 BEHAVIORAL HEALTH ENTITY CONTRACTING

8.372.3.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.372.3.1 NMAC - N, 7/1/2024]

8.372.3.2 SCOPE: This rule applies to collaborative member agencies.

[8.372.3.2 NMAC - N, 7/1/2024]

8.372.3.3 STATUTORY AUTHORITY: Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority (HCA). The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.372.3.3 NMAC - N, 7/1/2024]

8.372.3.4 DURATION: Permanent.

[8.372.3.4 NMAC - N, 7/1/2024]

8.372.3.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.372.3.5 NMAC - N, 7/1/2024]

8.372.3.6 OBJECTIVE: The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.

[8.372.3.6 NMAC - N, 7/1/2024]

8.372.3.7 DEFINITIONS: [RESERVED]

[8.372.3.7 NMAC - N, 7/1/2024]

8.372.3.8 MISSION STATEMENT: The mission of the collaborative is to ensure that quality behavioral health services are provided to medicaid and non-medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of

substance abuse and mental illness are prevented or reduced.
[8.372.3.8 NMAC - N, 7/1/2024]

8.372.3.9 ELIGIBLE BEHAVIORAL HEALTH ENTITY (BHE): The collaborative shall award a contract to one or more behavioral health entities which meets applicable requirements and standards delineated under state and federal law including Title IV of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. The BHE contract shall, at a minimum, manage delivery of all covered behavioral health services (both medicaid and non-medicaid services), including network development and management, tracking funding and expenditures from various funding sources, conducting utilization management, ensuring coordination of services, ensuring quality management and improvement, and conducting various administrative functions.

A. BHE contract procurement: The collaborative may, in conjunction with the HCA, jointly procure contractors to provide both BH and other medicaid services.

B. BHE contract issuance: Prior to execution of a contract with a BHE, the collaborative must meet and give approval as to the substance and form of the proposed contract. The executive committee is authorized to negotiate, sign and execute the contract with a BHE without further approval from the other members.

C. BHE contract amendments: The BHE contract shall not be altered, changed or amended other than by an instrument in writing executed by the contractor and the co-chairs of the collaborative. The executive committee is authorized to adopt and execute an amendment to a BHE contract on behalf of the collaborative without obtaining prior approval of the other members.

D. Other contracts: The chair and co-chairs are authorized to negotiate any additional contracts, memoranda of understanding or other agreements, and any amendments or modifications thereto, on behalf of the collaborative without obtaining the prior approval of the members.
[8.372.3.9 NMAC - N, 7/1/2024]

8.372.3.10 [RESERVED]
[8.372.3.10 NMAC - N, 7/1/2024]

8.372.3.11 READINESS REVIEW: Following full execution and prior to the effective date of the BHE contract, the contractor shall demonstrate to the satisfaction of the collaborative that it is able to meet the requirements of the RFP. The readiness review may include, but is not limited to, desk and on-site reviews, system demonstrations, interviews with the contractor's staff and such other review of any and all requirements of the RFP as determined by the collaborative.
[8.372.3.11 NMAC - N, 7/1/2024]

8.372.3.12 CONTRACT MANAGEMENT: The collaborative or its designee shall provide collective and coordinated oversight and administrative functions to ensure BHE compliance with the terms of its contract, assuring each member agency with fiduciary responsibility for funds within the contract is involved and is able to meet its obligations to oversee state and federal funds for which it is responsible. Further, the provisions of 8.305.3.10 NMAC apply to all BHE contracts.
[8.372.3.12 NMAC - N, 7/1/2024]

HISTORY OF 8.372.3 NMAC: [RESERVED]

HUMAN SERVICES DEPARTMENT

The Human Services Department will become the Health Care Authority (HCA) effective July 1, 2024. By virtue of the statutory authority and jurisdiction given to the HCA, the Department is repealing an older version of each of the following rules and replacing it with an updated version that changes the department's name, updates its statutory authority, and follows current NMAC formatting rules:

The Human Services Department, which will become the Health Care Authority approved the repeal of 7.21.1 NMAC - Behavioral Health - General Provisions (filed 7/29/2011) and replaced it with 8.372.1 NMAC - Behavioral Health - General Provisions (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority approved the repeal of 7.21.2 NMAC - Standards Of Delivery For Behavioral Health Services (filed 7/29/2011) and replaced it with 8.372.2 NMAC - Standards Of Delivery For Behavioral Health Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority approved the repeal of 7.21.3 NMAC - Behavioral Health Entity Contracting (filed 7/29/2011) and replaced it with 8.372.3 NMAC - Behavioral Health Entity Contracting (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.21.540 NMAC - Emergency Assistance Programs, Aid To Families With Dependent Children - Child Safety Restraint Seat Program (filed 9/15/1995) and replaced it with 8.21.540 NMAC - Emergency Assistance Programs, Aid To Families With Dependent Children - Child Safety Restraint Seat Program (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of

8.50.105 NMAC - Intake (filed 12/13/2010) and replaced it with 8.50.105 NMAC - Intake (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.50.106 NMAC - Location (filed 12/13/2010) and replaced it with 8.50.106 NMAC - Location (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.50.107 NMAC - Determination Of Parentage (filed 12/30/2009) and replaced it with 8.50.107 NMAC - Determination Of Parentage (adopted on 6/10/2024) effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.50.116 NMAC - Native American Initiative (filed 5/14/2001) and replaced it with 8.50.116 NMAC - Native American Initiative (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.100 NMAC - General Operating Procedures (filed 3/26/2001) and replaced it with 8.100.100 NMAC - General Operating Procedures (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.110 NMAC - General Operating Policies - Applications(filed 3/26/2001) and replaced it with 8.100.110 NMAC - General Operating Policies - Applications (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.120 NMAC - General Operating Policies - Case Management - Applications(filed 3/26/2001) and replaced it with 8.100.120 NMAC - General Operating Policies - Case Management - Applications (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.130 NMAC - General Operating Policies - Eligibility And Verification Standards (filed 7/17/2008) and replaced it with 8.100.130 NMAC - General Operating Policies - Eligibility And Verification Standards (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.150 NMAC - General Operating Policies - Record Retention/Management (filed 3/26/2001) and replaced it with 8.100.150 NMAC - General Operating Policies - Record Retention/Management (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.180 NMAC - General Operating Policies - External Communications (filed 3/26/2001) and replaced it with 8.100.180 NMAC - General Operating Policies - External Communications (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.390 NMAC - General Support - Information Systems (filed 3/26/2001) and replaced it with 8.100.390 NMAC - General Support - Information Systems (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.110 NMAC - General Operating Policies - Applications (filed 6/18/2001) and replaced it with 8.102.110 NMAC - General Operating Policies - Applications (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.120 NMAC - Eligibility Policy - Case Administration (filed 6/18/2001) and replaced it with 8.102.120 NMAC - Eligibility Policy - Case Administration (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.230 NMAC - General Financial - Payables And Dispersement (filed 6/18/2001) and replaced it with 8.102.230 NMAC - General Financial - Payables And Dispersement (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.400 NMAC - Recipient Policies - Defining The Assistance Group (filed 6/18/2001) and replaced it with 8.102.400 NMAC - Recipient Policies - Defining The Assistance Group (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.410 NMAC - Recipient Policies - General Recipient Requirements (filed 6/18/2001) and replaced it with 8.102.410 NMAC - Recipient Policies - General Recipient Requirements (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.420 NMAC - Recipient Policies - Special Recipient Requirements (filed 6/18/2001) and replaced it with 8.102.420 NMAC - Recipient Policies - Special Recipient Requirements (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department,

which will become the Health Care Authority, approved the repeal of 8.102.500 NMAC - Eligibility Policy - General Information (filed 6/18/2001) and replaced it with 8.102.500 NMAC - Eligibility Policy - General Information (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.501 NMAC - Transition Bonus Program (filed 6/2/2008) and replaced it with 8.102.501 NMAC - Transition Bonus Program (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.510 NMAC - Eligibility Policy - Resources/Property (filed 6/18/2001) and replaced it with 8.102.510 NMAC - Eligibility Policy - Resources/ Property (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.520 NMAC - Eligibility Policy - Income (filed 6/18/2001) and replaced it with 8.102.520 NMAC - Eligibility Policy - Income (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.610 NMAC - Description Of Program/Benefits - Benefit Delivery (filed 6/18/2001) and replaced it with 8.102.610 NMAC - Description Of Program/Benefits - Benefit Delivery (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.611 NMAC - Education Works Program (filed 11/30/2005) and replaced it with 8.102.611 NMAC - Education Works Program (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.620 NMAC - Description Of Program Benefits - Benefit Determination/General (filed 6/18/2001) and replaced it with 8.102.620 NMAC - Description Of Program Benefits - Benefit Determination/General (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.106.110 NMAC - General Operating Policies - Applications (filed 6/17/2004) and replaced it with 8.106.110 NMAC - General Operating Policies - Applications (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.106.120 NMAC - Eligibility Policy - Case Administration (filed 11/17/2009) and replaced it with 8.106.120 NMAC - Eligibility Policy - Case Administration (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.106.230 NMAC - General Financial - Payables And Disbursement (filed 11/17/2009) and replaced it with 8.106.230 NMAC - General Financial - Payables And Disbursement (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.110 NMAC - General Operating Policies Applications (filed 3/6/2001) and replaced it with 8.119.110 NMAC - General Operating Policies Applications (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.410 NMAC - Recipient Policies -General Recipient Requirements (filed 3/2/2001) and replaced it with 8.119.410 NMAC - Recipient Policies -General Recipient Requirements (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.500 NMAC - Eligibility Policy-General Information (filed 3/2/2001) and replaced it with 8.119.500 NMAC - Eligibility Policy-General Information (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.510 NMAC - Eligibility Policy-Resources/Property (filed 3/2/2001) and replaced it with 8.119.510 NMAC - Eligibility Policy-Resources/ Property (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.100 NMAC - General Provisions For The Low Income Home Energy Assistance Program (filed 9/17/2000) and replaced it with 8.150.100 NMAC - General Provisions For The Low Income Home Energy Assistance Program (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.110 NMAC - Applications (filed 9/17/2001) and replaced it with 8.150.110 NMAC - Applications (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.410 NMAC - General Recipient Requirements (filed 9/17/2001) and replaced it with 8.150.410 NMAC - General Recipient Requirements (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department,

which will become the Health Care Authority, approved the repeal of 8.150.500 NMAC - Eligibility (filed 9/17/2001) and replaced it with 8.150.500 NMAC - Eligibility (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.510 NMAC - Resources/Property (filed 9/17/2001) and replaced it with 8.150.510 NMAC - Resources/Property (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.520 NMAC - Income (filed 9/17/2001) and replaced it with 8.150.520 NMAC - Income (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.600 NMAC - Description Of Program/Benefits (filed 9/17/2001) and replaced it with 8.150.600 NMAC - Description Of Program/Benefits (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, which will become the Health Care Authority, approved the repeal of 8.150.620 NMAC - Benefit Determination General (filed 9/17/2001) and replaced it with 8.150.620 NMAC - Benefit Determination General (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.624 NMAC - Retroactive Benefit Coverage (filed 9/17/2001) and replaced it with 8.150.624 NMAC - Retroactive Benefit Coverage (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.200.450 NMAC - Reporting Requirements (filed 12/18/2000) and replaced it with 8.200.450 NMAC - Reporting Requirements (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.201.500 NMAC - Income And Resource Standards (filed 9/2/2009) and replaced it with 8.201.500 NMAC - Income And Resource Standards (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.206.500 NMAC - Income And Resource Standards (filed 12/15/2001) and replaced it with 8.206.500 NMAC - Income And Resource Standards (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.206.600 NMAC - Benefit Description (filed 9/13/2013) and replaced it with 8.206.600 NMAC - Benefit Description (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.240.400 NMAC - Recipient Policies (filed 6/13/2003) and replaced it with 8.240.400 NMAC - Recipient Policies adopted on 6/10/2024, effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.240.500 NMAC - Income And Resource Standards (filed 6/25/2010) and replaced it with 8.240.500 NMAC - Income And Resource Standards adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.240.600 NMAC - Benefit Description (filed 9/3/2013) and replaced it with 8.240.600 NMAC - Benefit Description adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.245.400 NMAC - Recipient Policies (filed 11/16/2009) and replaced it with 8.245.400 NMAC - Recipient Policies adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.245.500 NMAC - Income And Resource Standards (filed 11/16/2009) and replaced it with .245.500 NMAC - Income And Resource Standards adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.248.400 NMAC - Recipient Policies (filed 1/13/2006) and replaced it with 8.248.400 NMAC - Recipient Policies (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.248.500 NMAC - Income And Resource Standards (filed 1/13/2006) and replaced it with 8.248.500 NMAC - Income And Resource Standards (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.248.600 NMAC - Benefit Description (filed 1/13/2006) and replaced it with 8.248.600 NMAC - Benefit Description adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.252.400 NMAC - Recipient Policies (filed 6/14/2002) and replaced it with 8.252.400 NMAC - Recipient Policies

NMAC adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.280.500 NMAC - Income And Resource Standards (filed 11/15/2006) and replaced it with 8.280.500 NMAC - Income And Resource Standards adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.285.500 NMAC - Income And Resource Standards (filed 11/17/2008) and replaced it with 8.285.500 NMAC - Income And Resource Standards adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.285.600 NMAC - Benefit Description (filed 11/17/2008) and replaced it with 8.285.600 NMAC - Benefit Description adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.290.500 NMAC - Income And Resource Standards (filed 4/16/2002) and replaced it with 8.290.500 NMAC - Income And Resource Standards adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.1 NMAC - General Program Description (filed 4/16/2004) and replaced it with 8.300.1 NMAC - General Program Description adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.2 NMAC - Health Insurance Portability And Accountability Act Of 1996 (Hipaa) Policies (filed 6/16/2003) and replaced it with 8.300.2 NMAC - Health Insurance Portability And Accountability Act Of 1996 (Hipaa) Policies adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.6 NMAC - Responsibility And Delegation Of Authority (filed 3/25/2009) and replaced it with 8.300.6 NMAC - Responsibility And Delegation Of Authority adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.11 NMAC - Conflict of Interest (filed 6/16/2003) and replaced it with 8.300.11 NMAC - Conflict of Interest (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.17 NMAC - Conflict Of Interest (filed 6/16/2003) and replaced it with 8.300.17 NMAC - Conflict Of Interest adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.21 NMAC - Medical Assistance Division Policy Manual (filed 3/25/2009) and replaced it with 8.300.21 NMAC - Medical Assistance Division Policy Manual adopted on 6/10/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.301.5 NMAC - Medical Management (filed 6/14/2001) and replaced it with 8.301.5 NMAC - Medical Management (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.301.6 NMAC - Client Medical Transportation Services (filed 2/14/2011) and replaced it with 8.301.6 NMAC - Client Medical Transportation Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.302.1 NMAC - General Provider Policies (filed 12/9/2022) and replaced it with 8.302.1 NMAC - General Provider Policies (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.302.4 NMAC - Out-Of-State And Border Area Providers (filed 7/24/2008) and replaced it with 8.302.4 NMAC - Out-Of-State And Border Area Providers (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.310.4 NMAC - Federally Qualified Health Center Services (filed 10/12/2004) and replaced it with 8.310.4 NMAC - Federally Qualified Health Center Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.311.2 NMAC - Hospital Services (filed 12/24/2008) and replaced it with 8.311.2 NMAC - Hospital Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.313.2 NMAC - Intermediate Care Facilities For The Mentally Retarded (filed 10/17/2000) and replaced it with 8.313.2 NMAC - Intermediate Care Facilities For The Mentally Retarded (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.313.3 NMAC - Cost Related Reimbursement Of Icf-Mr Facilities

(filed 10/18/2000) and replaced it with 8.313.3 NMAC - Cost Related Reimbursement Of Icf-Mr Facilities (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.315.2 NMAC - Program Of All-Inclusive Care For The Elderly (Pace) (filed 11/15/2006) and replaced it with 8.315.2 NMAC - Program Of All-Inclusive Care For The Elderly (Pace) (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.324.10 NMAC - Ambulatory Surgical Center Services (filed 10/12/2004) and replaced it with 8.324.10 NMAC - Ambulatory Surgical Center Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.2 NMAC - Dialysis Services (filed 10/15/2004) and replaced it with 8.325.2 NMAC - Dialysis Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.4 NMAC - Hospice Care Services (filed 2/13/2006) and replaced it with 8.325.4 NMAC - Hospice Care Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.9 NMAC - Home Health Services (filed 1/18/1995) and replaced it with 8.325.9 NMAC - Home Health Services (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.10 NMAC - Emergency Medical Services For Non-Citizens (filed (11/14/2003) and replaced it with 8.325.10 NMAC - Emergency Medical Services For Non-Citizens (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.326.2 NMAC - Case Management Services For Adults With Developmental Disabilities (filed 1/18/1995) and replaced it with 8.326.2 NMAC - Case Management Services For Adults With Developmental Disabilities (adopted on 6/10/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.349.2 NMAC - Appeals And Grievance Process (filed 2/13/2006) and replaced it with 8.349.2 NMAC - Appeals And Grievance Process (adopted on 6/10/2024), effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 21 TRANSPORTATION ASSISTANCE AND SUPPORT
PART 540 EMERGENCY ASSISTANCE PROGRAMS, AID TO FAMILIES WITH DEPENDENT CHILDREN - CHILD SAFETY RESTRAINT SEAT PROGRAM

8.21.540.1 ISSUING AGENCY: New Mexico Health Care Authority, Income Support Division.
[8.21.540.1 NMAC - Rp 8.21.540.1 NMAC, 7/1/2024]

8.21.540.2 SCOPE: The rule applies to the general public.
[8.21.540.2 NMAC - Rp 8.21.540.2 NMAC, 7/1/2024]

8.21.540.3 STATUTORY AUTHORITY: Article 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children program (AFDC). Title IV of the Social Security Act and the rules and regulations of the federal department of health, education and welfare, carried under Title 45, Code of Federal Regulations, established the requirements for state plans for assistance to families with dependent children. 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.
[8.21.540.3 NMAC - Rp 8.21.540.3 NMAC, 7/1/2024]

8.21.540.4 DURATION: Permanent.
[8.21.540.4 NMAC - Rp 8.21.540.4 NMAC, 7/1/2024]

8.21.540.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.21.540.5 NMAC - Rp 8.21.540.5 NMAC, 7/1/2024]

8.21.540.6 OBJECTIVE: The objective of the AFDC - emergency assistance child safety restraint seat program is to assist needy children and their families by providing newborn children with child safety restraint seats. The seats, as well as training on their use, will be provided to families with a newborn child upon their release from a hospital. The program is a joint effort between HCA and the department of health (DOH) as DOH is responsible for assuring the health and safety of New Mexico residents. In such capacity, DOH has agreed to obtain and distribute child safety restraint seats for the purpose of the EACSRS program.
[8.21.540.6 NMAC - Rp 8.21.540.6 NMAC, 7/1/2024]

8.21.540.7 DEFINITIONS: [**RESERVED**]
[8.21.540.7 NMAC - Rp 8.21.540.7 NMAC, 7/1/2024]

8.21.540.8 ELIGIBILITY

REQUIREMENTS: Eligibility is based upon four requirements: destitution, emergency situation, compliance with project forward components, and birth.

A. Destitution: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, an applicant's respective family is required to receive AFDC and provide documentation of such. Consequently, in order to receive a child safety restraint seat and the associated training, applicant families will be required to present proof of AFDC benefits, preferably by presenting their medicaid card.

B. Emergency situation: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, applicants are required to be in an emergency situation. Consequently, an emergency situation needs to be designated by respective hospital personnel.

C. Compliance with project forward components: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, applicant's respective families must have complied with project forward components. The emergency condition must not have arisen because an adult family member refused to accept employment or training for employment.

D. Birth requirements: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, applicant's respective families must have recently given birth. Applicants must receive benefits upon their first release from the hospital.

[8.21.540.8 NMAC - Rp 8.21.540.8 NMAC, 7/1/2024]

HISTORY OF 8.21.540 NMAC: [**RESERVED**]

History of Repealed Material: 8 NMAC 21 EAP. 5408.21.540 NMAC - Emergency Assistance Programs, Aid To Families With Dependent Children - Child Safety Restraint Seat Program (filed 9/15/1995) Repealed effective, 7/1/2024.

Other: 8 NMAC 21 EAP. 5408.21.540 NMAC - Emergency Assistance Programs, Aid To Families With Dependent Children - Child Safety Restraint Seat Program (filed 9/15/1995) Replaced by 8.21.540 NMAC - Emergency Assistance Programs, Aid To Families With Dependent Children - Child Safety Restraint Seat Program , effective, 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 105 INTAKE

8.50.105.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.105.1 NMAC - Rp 8.50.105.1 NMAC, 7/1/2024]

8.50.105.2 SCOPE: To the general public. For use by the IV-D agency and recipients of IV-D services.
[8.50.105.2 NMAC - Rp 8.50.105.2 NMAC, 7/1/2024]

8.50.105.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). 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.
[8.50.105.3 NMAC - Rp 8.50.105.3 NMAC, 7/1/2024]

8.50.105.4 DURATION: Permanent.
[8.50.105.4 NMAC - Rp 8.50.105.4 NMAC, 7/1/2024]

8.50.105.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.50.105.5 NMAC - Rp 8.50.105.5 NMAC, 7/1/2024]

8.50.105.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.105.6 NMAC - Rp 8.50.105.6 NMAC, 7/1/2024]

8.50.105.7 DEFINITIONS: [**RESERVED**]
[8.50.105.7 NMAC - Rp 8.50.105.7 NMAC, 7/1/2024]

8.50.105.8 PROVISION OF SERVICES: The IV-D agency shall provide services to anyone who has filed a proper application for services.

A. Services to residents and non-residents: Services will be made available to residents of other states on the same terms as to residents of the state of New Mexico. The IV-D agency shall not be required to provide services when neither party resides in the state of New Mexico and the state is not actively seeking reimbursement of public assistance paid. There is no citizenship requirement as a pre-condition for Title IV-D services.

B. Provision of services for recipients of other benefit programs: Federal regulations also require the IV-D agency to provide services equally to intrastate and interstate cases, including IV-D, IV-E, medicaid only, and non-IV-A cases. Information detailing the services offered by the IV-D agency, the responsibilities of the custodial party, the IV-D agency's fee schedule, and requirements to cooperate must be provided to all recipients of IV-A and medicaid benefits within five days of referral to the IV-D agency. The IV-A agency provides this information to

all applicants/recipients of IV-A and medicaid benefits when the IV-A case is opened.

C. Provision of services when all dependents are emancipated:

(1) Intrastate cases: The IV-D agency will not accept an application or re-open a closed case for the establishment or enforcement of a support order when all dependents are emancipated. The existence of a public assistance benefit history does not obligate the IV-D agency to pursue or re-open a case when the dependents are emancipated.

(2) Interstate cases: The IV-D agency will not establish paternity or an order of support after all dependents are emancipated. The IV-D agency will, however, enforce an existing order of support when all dependents are emancipated in accordance with Section 40-6A-101 et seq. NMSA 1978.

[8.50.105.8 NMAC - Rp, 8.50.105.8 NMAC, 7/1/2024]

8.50.105.9 NON-PUBLIC ASSISTANCE APPLICATIONS: The IV-D agency shall make applications for child support services readily accessible to the public. When an individual requests an application for IV-D services, the application shall be provided on the day the individual makes the request in person. The application shall be sent within no more than five working days of a written or telephone request. An application is considered to be filed on the day it is received by the IV-D agency. The IV-D agency shall not accept applications from individuals seeking to pursue claims of parentage or support against their biological or adoptive parents.

[8.50.105.9 NMAC - Rp 8.50.105.9 NMAC, 7/1/2024]

8.50.105.10 PROCESSING REFERRALS AND APPLICATIONS: For all cases appropriately referred and for all applications, federal regulations mandate that within 20 calendar days of receipt of an appropriate referral or application submitted to the IV-D agency, the IV-D staff opens a case by establishing a case record. Based on an assessment of the case to determine necessary action, within the same 20 calendar days the IV-D agency must:

A. solicit necessary and relevant information from the custodial party and other relevant sources;

B. initiate verification of information, which may include interviewing the custodial party to determine the next action on the case; and

C. if there is inadequate information to proceed, a request for additional information must be made or the case referred for parent location services.

[8.50.105.10 NMAC - Rp 8.50.105.10 NMAC, 7/1/2024]

8.50.105.11 GENERAL REQUIREMENTS FOR APPLICANTS AND RECIPIENTS OF IV-D BENEFITS:

A. Title IV-D applicants and recipients: The state IV-D agency will provide services relating to the establishment of paternity or the establishment, modification, or enforcement of support obligations for a child, as appropriate, under the plan with respect to each child for whom:

(1) assistance is provided under the state program funded under Title IV-A of the Social Security Act;

(2) benefits or services for foster care maintenance are provided under the state program funded under Title IV-E of the Social Security Act;

(3) medical assistance is provided under the state plan approved under Title XIX of the Social Security Act and an assignment of support rights is indicated;

(4) any other child, if an individual, who is either a biological parent, adoptive parent, or a legal custodian of the child, applies for such services with respect to the child.

B. Title IV-A, IV-E foster care, and medicaid only recipients: Appropriate recipients of Title IV-A, IV-E foster care, and medicaid only (where an assignment of rights is indicated and cooperation is required) are referred to the IV-D program and are eligible for all IV-D services. When a family needs support from a non-custodial parent and is approved for IV-A, IV-E foster care, non-IV-E medicaid, or medicaid benefits, a referral is made to the IV-D regional office. The medicaid only recipient, who has assigned support rights and whose cooperation is required, must receive medical support services but can decline receipt of all other IV-D services. In addition, post-IV-A recipients will continue to receive IV-D services until they inform the division that they no longer desire these services.

C. Non-IV-A applicants: Non-IV-A families can apply for program services through the completion of a non-IV-A application for services.

D. Non-resident applicant: A non-resident applicant who applies for services through the IV-D agency in their state of residence is eligible for assistance from the New Mexico IV-D program under applicable laws, so long as the other party resides in the state of New Mexico.

E. Non-custodial parent applicant: The non-custodial parent can apply for program services for the purpose of establishing paternity, child support, medical support, making support payments, or to request a review of an existing child support court order. Any other person or entity who has standing to request an adjustment to the child support order may apply for services.

[8.50.105.11 NMAC - Rp 8.50.105.11 NMAC, 7/1/2024]

8.50.105.12 SUPPORT ASSIGNMENT AND COOPERATION REQUIREMENTS:

A. Cooperation with the IV-D agency is required of all recipients of IV-D services regardless

of public assistance benefit status. The IV-D agency pursues sanction and disqualification of recipients of services, as appropriate, and may close any IV-D case for a failure to cooperate. Cooperation includes, but is not limited to:

(1) providing all information regarding the identity and location of the absent parent (including the names of other persons who may have information regarding the identity or location of the absent parent);

(2) appearing for scheduled appointments;

(3) reviewing and signing forms and court documents;

(4) providing documentation relevant to the claim for an award of support;

(5) appearing at court or administrative hearings, as required;

(6) immediately notifying the IV-D agency if the dependent(s) is no longer in the care or custody of the custodial party;

(7) reporting all direct payments made to the custodial party prior to and during the provision of services by the IV-D agency;

(8) immediately notifying the IV-D agency if the dependent(s) is involved in adoption proceedings;

(9) keeping the IV-D agency informed of changes in contact information; and

(10) providing all requested information to the IV-D agency in a timely manner.

B. If there is an assignment of support rights pursuant to Section 27-2-28 NMSA 1978, the IV-D agency will request a sanction or disqualification of a member of a public assistance benefit group for noncompliance with IV-D agency cooperation requirements. The IV-D agency will notify the appropriate agency of compliance if the custodial party resolves the issue of noncompliance with the IV-D agency.

(1) IV-A public assistance benefits - referrals for sanctions or disqualifications are sent to and handled by the IV-A agency.

(2) Title XIX medicaid - if there is an assignment of support rights and cooperation is mandated, the IV-D agency will request disqualification of the member that is not cooperating with the IV-D agency. The disqualification status continues until the member cooperates with the IV-D agency.

[8.50.105.12 NMAC - Rp 8.50.105.12 NMAC, 7/1/2024]

8.50.105.13 BENEFITS OF COOPERATION: The establishment of a child's paternity may give the child rights to future social security, veteran's or other government benefits as well as inheritance rights should the non-custodial parent become disabled or deceased. The amount established for child support (with medical support) under child support award guidelines can help provide financially for the child. Medical support in the form of private health insurance can help provide for the medical needs of the child. Pursuant to federal law, the IV-D agency is required to make determinations related to custodial party cooperation in locating absent and alleged parents, establishing parentage, and establishing and enforcing support obligations in Title IV-A cases.

[8.50.105.13 NMAC - Rp 8.50.105.13 NMAC, 7/1/2024]

8.50.105.14 GOOD CAUSE FOR REFUSAL TO COOPERATE: In some cases it may be determined by the IV-D agency that the IV-A or medicaid applicant recipient's refusal to cooperate is with good cause.

A. Good cause may be claimed when the applicant's/recipient's cooperation in establishing paternity, securing child or medical support or pursuing liability for medical services is reasonably anticipated to result in the following:

(1) physical or emotional harm to the child for whom support is to be sought;

(2) physical or emotional harm to the caretaker/parent with whom the child is living that reduces the capacity to care for the child adequately.

B. Good cause may also be claimed when at least one of the following circumstances exist and the IV-D worker believes that proceeding to establish paternity, secure child or medical support or pursuing liability for medical services would be detrimental to the child for whom assistance is sought:

(1) the child was conceived as a result of incest or rape; or

(2) legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(3) the applicant/recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

C. Any person requesting a good cause exemption to a public assistance benefit requirement to cooperate, must fill out a request for a good cause exemption on a form provided by the IV-D agency and provide any documentation requested by the IV-D agency. The request for a good cause exemption will be reviewed by the IV-D agency and the requestor will be informed of the decision in writing. The requestor's failure to complete the form or provide the requested documentation will result in an automatic denial of the request.

[8.50.105.14 NMAC - Rp 8.50.105.14 NMAC, 7/1/2024]

8.50.105.15 DOMESTIC VIOLENCE AND CHILD ABUSE: The IV-D agency ensures that no information is released that may result in harm to any person related to a case. Reasonable evidence of domestic violence or child abuse is defined as the existence of a protective order or an affidavit

completed by the requesting person that indicates there is reasonable evidence that physical or emotional harm will occur if personal and locate information is released in the administration of the case. If there is an order for unsupervised visitation, the requestor must also demonstrate through documentation that to limit the release of information by presenting a copy of a protective order to the Title IV-D agency. The IV-D agency, however, cannot protect the name of a person(s). A custodial party or a non-custodial party using a substitute address pursuant to Section 40-13-11 NMSA 1978 must inform the Title IV-D agency of their current address when they are no longer participating in or have been denied the use of the substitute address through the New Mexico secretary of state's office.
[8.50.105.15 NMAC - Rp 8.50.105.15 NMAC, 7/1/2024]

History of 8.50.105 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 518.0000, Establishing The CSEB Case Record, 6/23/1980.
ISD CSEB 522.0000, Non-AFDC Forms, 6/23/1980.
ISD CSEB 522.0000, Non-AFDC Forms, 1/20/1981.
ISD CSEB 519.0000, Cooperation In Obtaining Support, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.105 NMAC, Intake, filed 5/14/2001 - Repealed effective 12/30/2010.
8.50.105 NMAC, Intake (filed 12/13/2010) - Repealed effective 7/1/2024.

Other:
8.50.105 NMAC, Intake (filed 12/13/2010) - Replaced by 8.50.105 NMAC, Intake (filed 12/13/2010) effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 106 LOCATION

8.50.106.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA) - Child Support Services Division.
[8.50.106.1 NMAC - Rp 8.50.106.1 NMAC, 7/1/2024]

8.50.106.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.106.2 NMAC - Rp 8.50.106.2 NMAC, 7/1/2024]

8.50.106.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). 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.
[8.50.106.3 NMAC - Rp 8.50.106.3 NMAC, 7/1/2024]

8.50.106.4 DURATION: Permanent.
[8.50.106.4 NMAC - Rp 8.50.106.4 NMAC, 7/1/2024]

8.50.106.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.50.106.5 NMAC - Rp 8.50.106.5 NMAC, 7/1/2024]

8.50.106.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.106.6 NMAC - Rp 8.50.106.6 NMAC, 7/1/2024]

8.50.106.7 DEFINITIONS: [**RESERVED**]
[8.50.106.7 NMAC - Rp 8.50.106.7 NMAC, 7/1/2024]

8.50.106.8 LOCATION OF NON-CUSTODIAL PARENTS: The state is required to use appropriate federal, interstate, and local location sources and to use appropriate state agencies and departments as authorized by state law in locating the non-custodial parent, or their employer, and all sources of income and assets.
[8.50.106.8 NMAC - Rp 8.50.106.8 NMAC, 7/1/2024]

8.50.106.9 TIME FRAMES FOR PARENT LOCATE: Federal regulations require that within 75 calendar days of determining that location is necessary, the Title IV-D agency will access all appropriate location sources.
[8.50.106.9 NMAC - Rp 8.50.106.9 NMAC, 7/1/2024]

8.50.106.10 VERIFICATION OF LOCATION: Location information must be verified prior to service of process. Federal regulations require that the Title IV-D case record contain documentation of the date, time, and name of each location source, even when the source failed to provide helpful information.
A. Location sources will be verified by a second source verification when necessary.
B. The following location sources are acceptable forms of location verification for single source verification:
(1) employer letter;
(2) driver's license or vehicle registration with a date of issuance which is 90 days or

less;

(3) federal, state and local agencies and departments sources; and

(4) personal knowledge as to the non-custodial parent's whereabout where the person is
willing to testify to that fact.
[8.50.106.10 NMAC - Rp 8.50.106.10 NMAC, 7/1/2024]

8.50.106.11 THE STATE PARENT LOCATOR SERVICE: The New Mexico Title IV-D agency established a state parent locator service (SPLS) that operates out of the agency's central office. The state parent locator service is authorized to submit location information requests to the federal parent locator service. If all attempts to locate a non-custodial parent fail at the local office level, these cases may be referred to the state parent locator service provided that at least the non-custodial parent's full name and either an approximate date of birth or social security number are known.
[8.50.106.11 NMAC - Rp 8.50.106.11 NMAC, 7/1/2024]

8.50.106.12 FEDERAL PARENT LOCATOR SERVICE (FPLS): The Title IV-D agency may utilize the FPLS in accordance with 42 USC 653 and 45 CFR § 303.70. All information obtained is subject to federal and state laws regarding confidentiality of information. Neither parties nor their respective private legal representative may apply directly to the SPLS for FPLS information in parental kidnapping and child custody cases. Parties or their respective legal representative may, however, petition a state district court to request location information from the FPLS concerning the absconding parent and missing child. A party can request appropriate state officials who are authorized persons to make a locate request. A state district court may request FPLS information in connection with a child custody determination in adoption and parental rights determination cases.
[8.50.106.12 NMAC - Rp 8.50.106.12 NMAC, 7/1/2024]

8.50.106.13 DECEASED PARTIES: If a party or dependent is reported as deceased, the death must be verified. Verification may consist of written verification from the vital statistics bureau, office of the medical investigator or from any other accepted official source.
[8.50.106.13 NMAC - Rp 8.50.106.13 NMAC, 7/1/2024]

8.50.106.14 STATE CASE REGISTRY: The Title IV-D agency established a state case registry that contains records with respect to:

A. each case in which services are being provided on or after October 1, 1998, by the state Title IV-D agency; and

B. each support order established or modified in the state on or after October 1, 1998, whether or not the order was obtained by the Title IV-D agency. (Section 27-1-8 et seq., NMSA 1978).
[8.50.106.14 NMAC - Rp 8.50.106.14 NMAC, 7/1/2024]

8.50.106.15 LOCATOR INFORMATION FROM INTERSTATE NETWORKS: The state Title IV-D agency is authorized to have access to any system used by the state to locate an individual for purposes relating to motor vehicle or law enforcement.
[8.50.106.15 NMAC - Rp 8.50.106.15 NMAC, 7/1/2024]

8.50.106.16 STATE DIRECTORY OF NEW HIRES: The HCA established a state directory of new hires pursuant to the state directory of New Hires Act ("Act"), Section 50-13-1 et seq., NMSA 1978. The HCA may, at its discretion, contract this service, as appropriate. All information required by the act may be provided to a contractor designated by the HCA.
[8.50.106.16 NMAC - Rp 8.50.106.16 NMAC, 7/1/2024]

History of 8.50.106 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 531.0000, Location Efforts at the Local Level, 6/23/1980.
ISD CSEB 539.0000, Use of the Federal Parent Locator Service (FPLS) in Parental Kidnapping and Child Custody Cases, 2/15/1983.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.106 NMAC, Location, filed 5/14/2001 - Repealed effective 12/30/2010.
8.50.106 NMAC, Location, filed 12/30/2010 - Repealed effective 7/1/2024.

Other: 8.50.106 NMAC, Location, filed 12/30/2010 Replaced by 8.50.106 NMAC, Location, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 107 DETERMINATION OF PARENTAGE

8.50.107.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.107.1 NMAC - Rp 8.50.107.1 NMAC, 7/1/2024]

8.50.107.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.107.2 NMAC - Rp 8.50.107.2 NMAC, 7/1/2024]

8.50.107.3 STATUTORY AUTHORITY: Public Assistance

Act, Section 27-2-27 et seq., NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). 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.
[8.50.107.3 NMAC - Rp 8.50.107.3 NMAC, 7/1/2024]

8.50.107.4 DURATION: Permanent.
[8.50.107.4 NMAC - Rp 8.50.107.4 NMAC, 7/1/2024]

8.50.107.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.50.107.5 NMAC - Rp 8.50.107.5 NMAC, 7/1/2024]

8.50.107.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.107.6 NMAC - Rp 8.50.107.6 NMAC, 7/1/2024]

8.50.107.7 DEFINITIONS: [**RESERVED**]
[8.50.107.7 NMAC - Rp 8.50.107.7 NMAC, 7/1/2024]

8.50.107.8 DETERMINATION OF PARENTAGE: A determination of parentage is necessary for the establishment of child support. The Title IV-D agency extends full faith and credit to a determination of parentage made by another jurisdiction, whether established through voluntary acknowledgment or through administrative or judicial process. Alleged fathers may initiate parentage actions through the Title IV-D agency. The Title IV-D agency may petition a court of competent jurisdiction to establish parentage so long as the dependent child is still under the age of majority.

A. Federal time-frames and requirements for establishment of parentage. The IV-D agency shall establish an order for support or complete service of process necessary to commence proceedings to establish a support order and, if necessary, parentage (or document unsuccessful attempts to serve process) within 90 calendar days of locating the alleged father or non-custodial parent. (45 CFR Section 303.4(d)).

B. The Title IV-D agency is not required to establish parentage or pursue genetic testing in any case involving incest or rape, or in any case in which legal proceedings for adoption are pending, or if, in the opinion of the IV-D agency, it would not be in the best interests of the child.

C. The Title IV-D agency may identify and use laboratories that perform, at reasonable cost, legally and medically acceptable genetic tests that tend to identify the biological parent or exclude the alleged biological parent. The IV-D agency may make available a list of such laboratories to appropriate courts and law enforcement officials, and to the public upon request.

D. The Title IV-D agency may seek entry of a default order by the court or administrative authority in a parentage case according to state law and rules of procedure regarding default orders.

E. The Title IV-D agency may seek to establish maternity in compliance with the New Mexico Uniform Parentage Act, as appropriate.

F. The IV-D agency will not initiate an action to rescind or disestablish parentage.

G. If a child in a Title IV-D case has an acknowledged, presumed, or an adjudicated father as defined within the New Mexico Uniform Parentage Act, then parentage has been determined and the Title IV-D agency will pursue the establishment of support on behalf of or against the parent, as appropriate.
[8.50.107.8 NMAC - Rp 8.50.107.8 NMAC, 7/1/2024]

8.50.107.9 PARENTAGE INVOLVING MINOR FATHERS AND MOTHERS: If the biological parent is under the age of emancipation, and is not otherwise emancipated by law, the Title IV-D agency will take measures to establish parentage and support, as appropriate. If a biological parent is a minor, their parent, legal guardian, or attorney who has entered an appearance on behalf of the minor biological parent may be present at all meetings or discussions between the minor biological parent and the representatives of the Title IV-D agency. The Title IV-D agency will seek to establish parentage. If the alleged minor non-custodial parent is employed, the Title IV-D agency will pursue guideline support. Any order or stipulation will include a requirement that the minor non-custodial parent will notify the Title IV-D agency of their employment and educational status on a regular basis. In uncontested cases, the Title IV-D agency may seek the concurrence of the minor biological parent's parent(s), legal guardian, or attorney. In contested cases, the minor biological parent(s) may request the court to appoint a guardian ad litem. Any legal notices or pleading prepared following the appointment of the guardian ad litem will be sent in accordance with the rules of civil procedure.
[8.50.107.9 NMAC - Rp 8.50.107.9 NMAC, 7/1/2024]

8.50.107.10 DETERMINATION OF PARENTAGE THROUGH VOLUNTARY ACKNOWLEDGMENT OF PATERNITY: State and federal laws provide for voluntary acknowledgment of paternity after the birth of a child. A man is determined to be the natural father of a child if he and the mother acknowledge parentage by filing a written acknowledgment with the vital statistics bureau of the public health division of the department of health, in accordance with the requirements of Article 3 of the New Mexico Uniform Parentage Act.

[8.50.107.10 NMAC - Rp 8.50.107.10 NMAC, 7/1/2024]

8.50.107.11 LONG ARM STATUTE CASES:

A. The Title IV-D agency will use the long arm statute as appropriate to exercise jurisdiction over a non-custodial parent residing in another state pursuant to Section 40-6A-201 et seq., NMSA 1978.

B. Genetic testing may be used in long arm statute cases in the establishment of parentage. New Mexico shall advance the costs associated with the testing in cases wherein the state initiated long arm statute actions. The Title IV-D agency shall seek reimbursement for the advancement of the costs pursuant to the genetic testing section below.

[8.50.107.11 NMAC - Rp 8.50.107.11 NMAC, 7/1/2024]

8.50.107.12 GENETIC TESTING:

A. The Title IV-D agency provides genetic testing services, as appropriate. The Title IV-D agency will not provide genetic testing services when parentage is presumed by law or has already been adjudicated unless ordered by a court of competent jurisdiction to do so. The Title IV-D agency will seek the admission into evidence, for purposes of establishing parentage, the results of a genetic test that are performed by a laboratory contracted with the Title IV-D agency to provide this specific service, unless the results are otherwise stipulated to by the parties. Any party to a Title IV-D case may seek genetic testing outside of the Title IV-D agency, at their own expense, and obtain a genetic test and report in compliance with Sections 40-11A-503 to 504 et seq., NMSA 1978. The Title IV-D agency will not present or introduce into evidence the results of a genetic test report obtained through a laboratory not contracted with the Title IV-D agency.

B. The Title IV-D agency may charge any individual who is not a recipient of state aid for the cost of genetic testing in accordance with the fee schedule in 8.50.125 NMAC. The Title IV-D agency may advance the cost of the fee if the IV-D agency is a party in a pending court case and is providing full services. If the Title IV-D agency is not a party in a pending court case and is not providing full services, the Title IV-D agency may require payment of the fee from any or all parties prior to scheduling the genetic testing. If a party paying any or all of the genetic testing fee wants reimbursement from the other party, they must seek a court order against that party.

C. The Title IV-D agency will charge a father for genetic testing when parentage is already presumed by law or has already been adjudicated, regardless of the results of the paternity test. The Title IV-D agency will charge an alleged father for genetic testing when parentage is not presumed by law or adjudicated and the results of the test show the alleged father to be the biological father. The Title IV-D agency will charge the mother for genetic testing when parentage is not presumed by law or adjudicated and the results of the test show the alleged father not to be the biological father.

[8.50.107.12 NMAC - Rp 8.50.107.12 NMAC, 7/1/2024]

8.50.107.13 JUDGMENTS AND ORDERS IN PARENTAGE CASES: The judgment or order of the court determining the existence or nonexistence of the parent and child relationship is determinative for all purposes. The IV-D agency will seek the following orders, as appropriate:

A. an order adjudicating parentage in accordance with the New Mexico Uniform Parentage Act, and

B. after parentage has been adjudicated, the establishment of child and medical support for the minor child(ren).

[8.50.107.13 NMAC - Rp 8.50.107.13 NMAC, 7/1/2024]

History of 8.50.107 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, filed 6/23/980.
ISD CSEB 551.0000, Procedures for the Establishment of Paternity, filed 6/23/1980.
ISD CSEB 555.0000, Blood Tests, filed 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, filed 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement, filed 12/30/1994 - Repealed effective 5/31/2001.
8.50.107 NMAC, Establishment of Paternity, filed 5/14/2001 - Repealed effective 1/1/2010.
8.50.107 NMAC, Establishment of Paternity, filed 12/30/2009 - Repealed effective 7/1/2024.

Other:
8.50.107 NMAC, Establishment of Paternity, filed 12/30/2009 Replaced by 8.50.107 NMAC, Establishment of Paternity, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 116 NATIVE AMERICAN INITIATIVE

8.50.116.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.

[8.50.116.1 NMAC - Rp 8.50.116.1 NMAC, 7/1/2024]

8.50.116.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of IV-D services.

[8.50.116.2 NMAC - Rp 8.50.116.2 NMAC, 7/1/2024]

8.50.116.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 NMSA

1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). 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.
[8.50.116.3 NMAC - Rp 8.50.116.3 NMAC, 7/1/2024]

8.50.116.4 DURATION: Permanent.
[8.50.116.4 NMAC - Rp 8.50.116.4 NMAC, 7/1/2024]

8.50.116.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.50.116.5 NMAC - Rp 8.50.116.5 NMAC, 7/1/2024]

8.50.116.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.116.6 NMAC - Rp 8.50.116.6 NMAC, 7/1/2024]

8.50.116.7 DEFINITIONS: [**RESERVED**]
[8.50.116.7 NMAC - Rp 8.50.116.7 NMAC, 7/1/2024]

8.50.116.8 CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES: The IV-D agency may enter into cooperative agreements with any or all of the 19 pueblos and three tribes that comprise the 22 separate Indian nations having lands located within the borders of New Mexico and with tribal IV-D agencies within the state of New Mexico. (42 USC 654 and 45 CFR Section 309). There is a specialized Native American initiative within the Title IV-D agency to deal with these matters.
[8.50.116.8 NMAC - Rp 8.50.116.8 NMAC, 7/1/2024]

History of 8.50.116 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6-23-80.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12-30-94.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.116.1 NMAC, Native American Initiative, (filed 5/14/2001) - Repealed effective 7/1/2024.

Other: 8.50.116.1 NMAC, Native American Initiative, (filed 5/14/2001) - Replaced by 8.50.116.1 NMAC, Native American Initiative, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 100 GENERAL OPERATING PROCEDURES

8.100.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.100.1 NMAC - Rp 8.100.100.1 NMAC, 7/1/2024]

8.100.100.2 SCOPE: The rule applies to the general public.
[8.100.100.2 NMAC - Rp 8.100.100.2 NMAC, 7/1/2024]

8.100.100.3 STATUTORY AUTHORITY:
A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations…." It also provides for administration of public assistance programs.
B. The income support division (ISD) of the health care authority was created by the secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.
C. 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.
[8.100.100.3 NMAC - Rp 8.100.100.3 NMAC, 7/1/2024]

8.100.100.4 DURATION: Permanent.
[8.100.100.4 NMAC - Rp 8.100.100.4 NMAC, 7/1/2024]

8.100.100.5 EFFECTIVE DATE: July 1, 2024, unless a different date is cited at the end of a section.
[8.100.100.5 NMAC - Rp 8.100.100.5 NMAC, 7/1/2024]

8.100.100.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.100.6 NMAC - Rp 8.100.100.6 NMAC, 7/1/2024]

8.100.100.7 DEFINITIONS: [**RESERVED**]
[8.100.100.7 NMAC - Rp 8.100.100.7 NMAC, 7/1/2024]

8.100.100.8 RULES AND REGULATIONS: The HCA secretary has authority to adopt rules and regulations governing the activities of HCA. These rules and regulations are subject to differing requirements regarding prior notice or hearing. This section details the differing types of rules and requirements relative to promulgation of those rules.
A. Regulations
(1) Internal rules: The HCA secretary has the authority to adopt rules governing the internal operations of the HCA without giving prior notice or opportunity for a hearing

(2) Permanent rules: The secretary approves final rules implementing proposals to adopt, amend or repeal HCA rules and regulations in accordance with the provisions and procedures set forth in Subsections B-F of 8.100.100.8 NMAC.

(3) Interim rulemaking: Under Subsection F of Section 9-8-6 NMSA 1978, the secretary may adopt interim rules where necessary due to reductions in federal funding which do not allow the time necessary to proceed through the regular rule promulgation process. In this process, the secretary must give at least 20 days individual notice of the change but, may then implement on an interim basis until the normal proposed rule publication and hearing process can be carried out. Following that process, the interim rule is superseded by the final rule developed in accordance with the provisions set forth below.

B. Notice of public hearing: A notice of public hearing on the proposed action shall include:

(1) description of the proposed action stated in a manner designed to be easily understood by individuals not knowledgeable in the field of administrative law;

(2) time, place and date of the public hearing on the proposed action, and name of contact person;

(3) manner in which interested individuals may present their views on the proposed action and the cost, if any, to an individual of a copy of the proposed regulations.

C. Publication of notice of public hearing: A public hearing notice is published once, at least 30 days before the hearing date, in at least one newspaper of general circulation in the state.

D. Request for advance notice: Anyone interested in routinely receiving notices of public hearings on HCA proposed rule-making actions may file a written request to be placed on a public notice mailing list. HCA mails copies of hearing notices to all such individuals at least 30 days before the hearing date.

E. Hearing procedures: A hearing is held in accordance with the hearing notice. HCA provides a reasonable opportunity for interested individuals to comment on and state their views regarding the proposed action. The hearing is conducted informally and the rules of evidence do not apply. HCA may, but is not required to, make a verbatim record of the hearing through stenographic notes, tape recording or similar methods.

F. Final decision by the secretary: After a public hearing, the secretary may adopt, change or reject the proposed action. The secretary's decision is delivered in writing, including the reasons for making it and a copy of any rule or regulation adopted or amended. The secretary takes reasonable steps to publicize the final decision but is not required to publish it in a manner other than that required under the State Rules Act unless otherwise required by law.

G. The adoption, amendment or repeal of a rule or regulation under this section is filed and becomes effective in accordance with the provisions of the State Rules Act.

[8.100.100.8 NMAC - Rp 8.100.100.8 NMAC, 7/1/2024]

8.100.100.9 MISSION STATEMENT:

A. ISD's primary mission is to relieve, minimize or eliminate poverty and to make available certain services for eligible low-income individuals and families through statewide programs of financial assistance, food assistance, and employment assistance and training services.

B. Human dignity and client rights: HCA has a commitment to respect for human dignity. Therefore, all programs are administered in a manner respectful of the dignity and personal privacy and rights of program beneficiaries. Discrimination based on personal judgments of a client's behavior, social status, religion, race, cultural patterns, personality, political beliefs, color, handicap or sex, is a violation of the law and a violation of ISD policy.

[8.100.100.9 NMAC - Rp 8.100.100.9 NMAC, 7/1/2024]

8.100.100.10 CATEGORIES OF ASSISTANCE: Each assistance program in which eligibility is determined under ISD2 (HCA's automated eligibility system), the HCA's eligibility and payment determination and issuance system is referred to as a category of assistance. A two-digit number is assigned to each category indicating the program of assistance. Following is a list of categories, program titles to which they refer, and the type of assistance provided under each. This listing is for informational purposes only.

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Category	Title	Explanat

01 03 04	aid to the aged, blind, and disabled	medical - former SSI cases eligible because of the disregard of social security increases received after July, 1977 (medicaid extension applies only to former SSI recipients).
02	NMW	financial and medical
05	general assistance	financial - temporary disability
06	non IV-E foster care	medical
08	general assistance	financial - unrelated children
09	general assistance	financial - permanent disability
10	state supplement for residential shelter care	financial - medical assistance for these cases is available based on SSI availability
14	refugee foster care	medical
17	IV-E adoption subsidy - established in another state	medical
19	refugee assistance	financial - medical
27	post-NMW medical	medical - four months medicaid coverage when NMW closing caused by increased child support
28	transitional medicaid	medical - up to 12 months medicaid coverage when NMW closing caused by increased earnings
30	medical assistance for women & children (MAWC)	medical - full medicaid coverage for pregnant women
31	medical assistance for women & children	medical - twelve months medicaid coverage for newborns
32	medical assistance for women & children	medical - for children born after September 30, 1983
33	medical assistance for women & children	medical - NMW denied because of deemed income from stepparents, alien sponsors, grandparents or siblings (deemed income is any income of another individual which is counted in determining the recipient's eligibility)
34	medical assistance for women & children	medical - SSI denials because of deemed income from stepparents or alien sponsors
35	medical assistance for women & children	medical - medicaid coverage restricted to pregnancy related matters for pregnant women
37	IV-E in-state adoption subsidy	medical
39	food stamps	food
40	qualified medicare beneficiary (QMB)	payment of medicare Part A premium and the coinsurance and deductible amounts on medicare covered services
42	qualified disabled working individuals	medical
45	specified low income medicare beneficiary	payment of medicare Part B premium for applicants who already have Part A. (state will not pay Part A premium).
46	out-of-state foster care	medical - no card issued, services by prior approval only
47	out-of-state adoption subsidy	medical - no card issued, services by prior approval only
49	refugee assistance	medical
	medical assistance for the seriously ill	
51	aged	medical
53	blind	medical
54	disabled	medical

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59	refugee medical assistance (spend down required)	medical
66	IV-E foster care	medical
	medical assistance for persons requiring institutional care	
81	aged	medical
83	blind	medical
84	disabled	medical
85	emergency assistance for ineligible aliens	medical
86	IV-E foster care custody out- of-state	medical
	in-home and community based medicaid waiver programs	
90	AIDS	medical
91	aged	medical
93	blind	medical
94	disabled	medical
95	medically fragile	medical
96	developmentally disabled	medical
97 98 99	aged developmentally disabled disabled/ blind	categories not eligible for federal matching funds under Title XIX. These categories were closed to new approvals effective November, 1989.

[8.100.100.10 NMAC - Rp 8.100.100.10 NMAC, 7/1/2024]

8.100.100.11 GENERAL PROGRAM DESCRIPTIONS:

A. NMW:

(1) Purpose: The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

(2) The program accomplishes this purpose by providing cash assistance, medical assistance, and work program services, including education, job training, and transportation to assist recipients in obtaining and keeping employment that is sufficient to sustain their families thereby ensuring the dignity of those who receive assistance and strengthening families and the families' support for their children.

(3) Legal basis: The New Mexico Works Act assigns responsibility for administration of the New Mexico works program to the health care authority. The governor of the state of New Mexico has designated the HCA as the TANF state agency in the state's biennial TANF block grant plan, pursuant to the requirements of Section 401 of Title IV-A of the federal Social Security Act.

B. General assistance:

(1) Purpose: General assistance (GA) is a limited program providing financial assistance to needy individuals and families who are not eligible for assistance under the New Mexico works program or under the federal supplemental security income (SSI) program. GA payments are made to:

(a) disabled adults who do not qualify for NMW who are not eligible for SSI because their disability is not severe enough;

(b) disabled adults who do not qualify for NMW;

(c) on behalf of children under 18 years of age who would be eligible for NMW except that they are not living with a person who is eligible to receive NMW; and

(d) SSI recipients who reside in licensed adult residential care homes.

(2) Legal basis: Section 27-1-3 NMSA (Repl. 1984) provides that "the state department shall: administer assistance to the needy, blind and otherwise handicapped and general relief."

C. Food stamps:

(1) Purpose: The food stamp program is designed to promote the general welfare and to safeguard the health and well-being of the nation's population by raising the

levels of nutrition among low-income households.

(2) Section 2 of the Food Stamp Act of 1977 states, in part: Congress hereby finds that the limited food purchasing power of low-income households contributes to hunger and malnutrition among members of such households. To alleviate such hunger and malnutrition, a food stamp program is herein authorized which will permit low-income households to obtain a more nutritious diet through normal channels of trade by increasing food purchasing power to all eligible households who apply for participation.

(3) Legal basis: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U. S. C. 2011 et seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. state authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration by HCA, including its authority to issue regulations, is governed by Chapter 9, Article 8 NMSA (Repl. 1983).

D. Refugee resettlement program:

(1) Purpose: The purpose of the refugee resettlement program (RRP) is to help refugees, political asylees and entrants, regardless of national origin, achieve economic self-sufficiency as quickly as possible. The purposes of the program are accomplished through financial and medical assistance while support services are provided to help refugees acclimate to American society, learn English and get a job. Federal legislation gives eligible refugees and their dependents financial and medical assistance through one hundred percent federal reimbursement to states, including administrative costs, for the first 18 months after entry into the United States.

(2) Legal basis: The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the U.S. department of health and human services as the federal administering agency. RRP program regulations are issued by DHHS in the Code of Federal Regulations Title 45, Part 400, supplemented by administrative and program instructions issued by the federal department from time to time. By Executive Order No. 80-62, dated 10/1/1981, the governor of the state of New Mexico has designated HCA as the single state agency responsible for administering the program in New Mexico.

E. Medical assistance programs:

(1) Medicaid:

(a) Purpose: Medicaid is a federally matched program that makes certain essential health care services available to eligible New Mexico residents who otherwise would not have the financial resources to obtain them. With certain exceptions, medicaid benefits are provided through "salud!", the HCA's medicaid managed care program.

(b) Eligible individuals include:

(i) families who meet New Mexico's AFDC requirements as it existed, or is considered to have existed, on July 16, 1996, as amended;

(ii) individuals who have been NMW recipients and are in transition to self-support due to employment, child support, or both;

(iii) pregnant women who meet income and resource requirements for the state's AFDC program as it existed, or is considered to have existed on July 16, 1996, as amended (full-coverage medicaid);

(iv) children under 19 years of age whose income is below one hundred eighty-five percent of federal poverty levels;

(v) pregnant women with income below one hundred eighty-five percent of federal income poverty levels (for pregnancy-related services);

(vi) recipients of assistance under the federal SSI program and those who have lost their SSI eligibility because of cost-of-living increases in Title II benefits;

(vii) aged, blind, and disabled individuals in institutions who meet all standards for SSI except income;

(viii) individuals who meet all standards for institutional care but can be cared for at home;

(ix) qualified medicare beneficiaries (QMBs), qualified disabled working individuals (QDs),

(x) and specified low income medicare beneficiaries (SLIMBs), limited coverage for medicare beneficiaries; and

(xi) certain foster children in the custody of the state.

(c) Legal basis: HCA is the single state agency designated to administer the New Mexico Title XIX medicaid program in accordance with 42 CFR 431.10, single state agency. State authority is provided by Section 27-2-12 NMSA 1978 (Repl. 1984). Title XIX of the Social Security Act and United States department of health and human services rules establish the requirements for state plans for medical assistance.

(2) Special medical needs:

(a) Purpose: The special medical needs program for seriously ill individuals is an entirely state-funded medical assistance program for individuals who suffer serious illnesses. Individuals applying under this program must be eligible according to New Mexico statutes and HCA policy. No new recipients are being added to this category.

(b) Legal basis: State authority for administering the special medical needs program is contained in Sections 27-4-1 to 27-4-5 NMSA 1978 (Repl. 1984).

(3) Medical

assistance to refugees

(a) Purpose: This program operates in accordance with the provisions of the medicaid program but is at present one hundred percent funded by the federal government. Medical assistance is provided to individuals and families qualifying for assistance under the refugee resettlement program.

(b) Legal basis: State authority for administering the medical assistance to refugees program is contained in Section 27-2-12 NMSA 1978 (Repl. 1984).

(4) Waivers for in-home care: The New Mexico department of health, under waivers from DHHS, provides certain in-home care services as an alternative to institutionalization. These waivers authorize services for: elderly, blind and physically handicapped individuals; developmentally disabled individuals; and medically fragile individuals, AIDS. Services under the waiver program are provided to both medicaid-eligible individuals and those who have income and resources in excess of medicaid standards. Within the HCA, the medical assistance division (MAD) is responsible for developing policy and regulations for these waiver programs.

F. Energy assistance:

(1) Purpose: Three energy assistance programs to assist low-income households during periods of high heating costs are administered by HCA:

(a) low income home energy assistance program (LIHEAP);

(b) emergency crisis intervention assistance program (ECIAP); and

(c) low income utility assistance program (LIUAP).

(2) Energy assistance is provided for home heating costs incurred during the months of November, December, January, and February of each year. The HCA may extend the program season by one or more months subject to the availability of supplemental state or federal funds.

(3) Legal basis: These programs are governed by the federal, state and other pertinent laws and regulations established for a defined program period, including but not limited to the following:
42 USC Section 8601: Chapter 94, Subchapter II, Low Income Home Energy Assistance Act (LIHEAA); Sections 27-6-11 to 27-6-16 NMSA 1978 (Repl. 1984) Low Income Utility Assistance Act (LIUAA).

(4) Funding for the LIHEAP and ECIAP programs is from the LIHEAA block grant.

G. Child support services:

(1) Every specified parent/relative caretaker who applies for or receives NMW from HCA is required, as a condition of eligibility, to make an assignment of support rights to the state and to cooperate with the state, if necessary, in establishing paternity and securing support.

(2) Exception: The cooperation requirement is not applied in cases where it would not be in the best interests of the child to cooperate.

(3) The provisions of the child support enforcement program are contained in Title IV-D of the Social Security Act, and the agency responsible for its implementation is frequently referred to as the IV-D agency. In New Mexico, the IV-D agency is the HCA child support services division (CSSD).
[8.100.100.11 NMAC - Rp 8.100.100.11 NMAC, 7/1/2024]

8.100.100.12 RESPONSIBILITY AND DELEGATION:

A. Division responsibilities: The income support division (ISD) is responsible for administering all relevant assistance programs in an accurate and timely fashion while treating clients with respect and dignity. The division administers those programs described in 8.100.100.10 NMAC, categories of assistance, and 8.100.100.11 NMAC, general program description.

B. Central office responsibilities: The division's central office includes the director, deputy directors and staff. Generally, central office is responsible for developing and managing division programs, program and organizational budgets and division personnel. It provides oversight and supervision of division field offices.

C. Field office responsibilities: ISD county field offices are located in the majority of counties in the state. Counties without ISD field offices may be served by scheduled itinerant visits. The county field office is the ISD unit responsible for the direct administration of ISD's food, medical, energy and financial assistance programs. The offices administer programs according to HCA regulations and policies. Each county office is supervised by a county director, who is responsible for the overall operation of the office, supervising office employees, and administering ISD programs. County directors report to and are supervised by ISD's deputy director for field operations.

D. Privacy:

(1) Procedures used to determine eligibility must respect the rights of the client under the United States constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, or any other relevant provisions of state and federal laws. Intrusions on a client's privacy and personal dignity are limited to what is reasonably necessary to make sure that expenditures made under the programs are accurate and legal.

(2) Prohibited activities: Specifically prohibited activities include:

(a) entering a home by force or without permission;

(b) making home visits outside of normal ISD working hours; and

(c) searching a home for clues of possible deception.
[8.100.100.12 NMAC - Rp 8.100.100.12 NMAC, 7/1/2024]

8.100.100.13 CONFIDENTIALITY:

A. Both the Social Security Act and the Food Stamp Act require the state agencies responsible for the administration of these programs to provide for the confidentiality of information about applicants for and recipients of program benefits.

B. "Confidential information" includes all information about an applicant for or recipient of program assistance contained in division records, as well as information obtained by division employees in their official capacity, whether such information is recorded or not. The term also includes records of division evaluations of recorded information. The term does not include general information of a statistical nature that cannot be identified with a particular individual or family group.

C. Access to Information: All information and documentation contained in a case record, with the exception of medical information and narrative dated before February 1, 1977, may be released to an adult family member or their representative on request. In financial assistance cases, confidential information is not released to the dependent children or the spouse (if not the other parent) of the specified relative, unless permission to do so is given by the specified relative.

D. Specific legal basis:

(1) Federal law: The Social Security Act, as amended, requires that state agencies administering the temporary assistance for needy families (TANF) program limit the release or use of information about applicants or recipients, including medical reports, to:

(a) purposes directly connected with the administration of TANF (Title IV-A), child support enforcement (Title IV-D), medicaid (Title XIX), social services (Title XX), SSA program (Title V), and SSI program (Title XVI);

(b) investigations, prosecutions or civil or criminal proceedings conducted in connection with the administration of these programs;

(c) agencies administering any other federal or federally-aided program which provides assistance in cash, in kind, or in services directly to individuals based on need, provided that the client's permission to release the information has been obtained in writing; the Food Stamp Act of 1977 and succeeding amendments require safeguards restricting the use or disclosure of information obtained from applicant or recipient households to persons directly connected with the administration or enforcement of the provisions of the act or regulations issued pursuant to the act.

(2) State law: Section 17 of the New Mexico Works Act of 1998 requires the HCA to establish and enforce rules governing the custody and use of records, papers, files and communications and restricting the use or disclosure of information in these documents concerning applicants and recipients of assistance in accordance with federal legislation.
[8.100.100.13 NMAC - Rp 8.100.100.13 NMAC, 7/1/2024]

8.100.100.14 CLIENT INFORMATION:

A. ISD case record:

(1) ISD case records, consisting of forms, records, narrative material, correspondence and documents, are scanned into electronic format and maintained in the HCA's secure electronic data management system. Documents submitted in person will be electronically scanned and returned to the individual. Original documents mailed to or left with the office will be photocopied and the originals mailed back to the client at their last known address known to the HCA. The copied documents will be electronically scanned and destroyed once successful completion of a scan into electronic format is confirmed. The case record documents the current and historical eligibility of a recipient group and thereby to establish the validity of decisions to approve or deny assistance.

(2) Case records are the property of the HCA and are established and maintained solely for use in the public assistance programs administered by the HCA. Information contained in the case record(s) is confidential and is released only under the limited circumstances and conditions as provided in federal and state laws and regulations, including Sections 13 through 15, 8.100.100 NMAC. Case records and their contents must remain in the possession of the HCA, its contractors, or approved federal employees. Copies of case records may be released in accordance with federal and state laws and regulations or pursuant to a court order.

(3) Electronic eligibility system information: Client information stored on the HCA's electronic eligibility system is subject to the same guidelines for release of information as the HCA's case record.

B. Persons with access to confidential information:

(1) Client: The name of an individual(s) providing confidential information to the HCA regarding a client is not released to a client or the client's authorized representative. The release of all other case information is subject to the following conditions:

(a) A client or their authorized representative must complete a request for access to a case record each time they wish to have access to the case record. If the client wishes to have their authorized representative review the record in their absence, the client must provide formal documentation authorizing the named individual(s) to access the identified case information for a specified purpose and time frame. This includes an individual(s) acting as

the client's authorized representative in a fair hearing. Only the client or the client's authorized representative may authorize another individual(s) to review the record.

(b) The record must be reviewed in the presence of the county director or designee.

(c) If a client disagrees with information contained in the case record, he or she may make a written rebuttal which is made part of the case record. Contested material may not be removed from the case record.

(2) Inquiries on client's behalf: Inquiries made on behalf of a client regarding eligibility for or amount of assistance received are treated as coming from private individuals, regardless of whether they come from a private citizen, elected official, or public or private agency. The HCA must receive formal documentation from the client or the client's authorized representative permitting the release of information.

(3) HCA employees: Confidential information is available to employees or agents of the HCA who need it in connection with the various services and public assistance programs administered by the HCA. This includes field and central office staff, representatives of the child support services division (CSSD) and medical assistance division (MAD), and private firms or other agencies under contract with the HCA that perform work or provide services related to public assistance programs. Confidential information is also available to employees of the federal government concerned with the public assistance programs administered by the HCA.

(4) Non-HCA employees: Confidential information about applicants for and recipients of public assistance may be released to other agencies or individuals including law enforcement officers that meet all of the following standards:

(a) agency or individual is involved in the administration of a federal or a federally-assisted program that provides assistance in cash, in kind or in services, directly to individuals on the basis of need;

(b) information is to be used for the purpose of establishing eligibility, determining amount of assistance or for providing services for applicants or recipients;

(c) agency or individual is subject to standards of confidentiality comparable to those of the HCA; and

(d) agency or individual has actual or implied consent of the applicant or recipient to release the information; in an emergency, information may be released without permission, but the client must be informed of its release immediately thereafter; consent may be considered as implied if a recipient or member of the assistance group has made application to the inquiring agency for a benefit or service.

(5) Funding agencies/auditors: The HCA's public assistance programs' funding agencies and auditors may have access to and use of client information and is subject to the confidentiality requirements specified above and in accordance with federal and state laws and regulations.

(6) Employers: To claim a tax credit on wages paid to cash assistance recipients, as provided under the Revenue Act of 1978, an employer may request and receive information from the HCA as to whether an employee is a recipient who meets the criteria for either:

(a) the welfare tax credit (NMW recipient during the three month period consisting of the month hired and the two months immediately preceding the date of hire); or

(b) the targeted jobs tax credit (recipient of GA who received GA for at least 30 days, ending within the 60 day period which ends on the hiring date). Such releases are to be made on a case by case basis and must be accompanied by a consent to release information signed by the client.

C. Medical records: Medical reports and medical information in the HCA's possession, regardless of how they were obtained, may not be shown to a client, unless they are released as part of a fair hearing. Because of the potentially upsetting nature of the facts contained in some reports and because a physician's knowledge is frequently necessary to interpret those facts, a client shall be referred to their physician regarding any questions.

D. Court proceedings:

(1) Program-related court cases:

(a) Criminal or civil court proceedings involving the establishment of paternity and enforcement of child and medical support for recipients, prosecution for fraud, suits for recovery of fraudulently obtained public assistance benefits, third-party recovery, and custody hearings regarding custody of children for whom public assistance is being provided are considered part of the public assistance programs administered by the HCA. The HCA or its interests may be represented in such cases by an attorney from the office of general counsel (OGC), CSSD, CYFD, by a local district attorney, by a representative of the attorney general's office or by a federal prosecutor.

(b) If information contained in a case record or known to an HCA employee is needed in preparation for or as part of a court proceeding, the HCA employee(s) will cooperate in making sure that needed information is supplied. Although employees may receive a subpoena to testify in such a court proceeding, a subpoena is not needed if the court proceeding relates to the public assistance programs administered by the HCA. To the extent possible, attorneys responsible for a case, or other persons helping in preparing the case for court action, will notify the HCA, or other custodian of a case record, in advance and in writing, of the need for court testimony, whether the record should be brought, and of the

time, date and place of hearing. If there is not enough time before the hearing to provide written notice, a phone call that the HCA logs in the narrative section of the case record, is sufficient. If it is not clear whether a court proceeding relates to the public assistance programs administered by the HCA, the local county office may contact the OGC or the appropriate division director's office for help.

(2) Non-program related court cases: Any person or attorney seeking confidential information from a case record for a non-program related court case should direct a properly issued subpoena to the appropriate local county office with a copy also sent to the HCA's OGC. The HCA will seek to preserve the confidentiality of the case record unless the release of the information is expressly authorized by federal and state laws and regulations or is otherwise ordered by a court of competent jurisdiction.
[8.100.100.14 NMAC - Rp 8.100.100.14 NMAC, 7/1/2024]

8.100.100.15 PUBLIC INFORMATION ACT:

A. Policy and procedures manual: The regulations for the public assistance programs administered by the HCA are located on the official website of the New Mexico administrative code located at http://www.nmcpr.state.nm.us/nmac/. Procedures and policy guidance is located at the official HCA website under the specified division at http://www.HCA.nm.gov. Copies of appropriate regulations and procedures and policy guidance will be provided to the claimant as part of the summary of evidence in a fair hearing pursuant to Subsection F of 8.100.970.10 NMAC.

B. State program and plan materials: The HCA state plans are available at the official HCA website under the specified division at http://www.HCA.nm.gov.

C. Other printed materials: Additional printed materials, such as brochures and pamphlets describing basic financial and nonfinancial eligibility criteria, the application process, and participant rights and responsibilities, are available at the local county offices, social security administration offices, state employment services offices, other agencies providing public assistance services, and the official HCA website at http://www.HCA.nm.gov.

D. Federal laws, regulations and other materials: Federal materials should be obtained by contacting the responsible federal agency directly. The university of New Mexico is a federal repository. Many federal agencies post regulations, planning documents and requirements as well as program instructions on the internet.
[8.100.100.15 NMAC - Rp 8.100.100.15 NMAC, 7/1/2024]

8.100.100.16 NONDISCRIMINATION/ PROGRAM ACCESS AND DELIVERY OF SERVICE:

A. Statement of nondiscrimination: HCA programs must be administered in a manner which makes sure that no person is denied any aid, care, services or other benefits on the grounds of race, color, age, sex, handicap, religious creed, national origin or political beliefs, or is otherwise subjected to unlawful discrimination.

B. Right to file complaint: Any individual who thinks they are being discriminated against because of race, color, sex, handicap, religious creed, national origin or political beliefs has the right to file a complaint with the central or any local HCA office, or with the U.S. department of health and human services, the U.S. department of justice, the U.S. department of agriculture, or the civil rights commission in Washington D.C.

(1) Complaint form: Individuals wishing to file complaints with HCA may use forms provided by ISD on request. A letter or statement, written or oral, expressing a belief of being unlawfully discriminated against is also accepted as a complaint.

(2) Unwritten complaints: If an individual alleges that a discriminatory act has been committed, but refuses or is reluctant to put the complaint in writing, the person receiving the complaint does so.

(3) Written complaints: Written complaints are accepted even if the information listed below in Paragraph 6 of Subsection B of 8.100.100.16 NMAC is incomplete.

(4) Investigation: HCA investigates any complaints received. Individuals making complaints are told whether unlawful discrimination is found to exist and what other action may be taken by complainants who are not satisfied with the decision.

(5) Food stamp complaint deadline: A complaint claiming unlawful discrimination in the food stamp program must be filed no later than 180 days after the date of the alleged discrimination. However, this deadline may be extended by the U.S. secretary of agriculture.

(6) Information needed:

(a) name, address and telephone number or other means of contacting complainant;

(b) location and name of individual/ agency responsible for delivering service and accused of discriminatory practices;

(c) nature of incident or action causing the complainant to allege unlawful discrimination; or an example of the aspect of the program administration which is alleged to harm potential participants or the individual making the complaint;

(d) basis on which complainant feels unlawful discrimination exists (age, race, handicap, sex, religious creed, color, national origin or political beliefs);

(e) names, titles and addresses of persons who may have knowledge of the discriminatory acts;

(f) date or dates on which the alleged discriminatory actions occurred.

C. Complaint system: Complaints regarding individual case deficiencies, such as processing standards or service to participants and applicants, are referred to the relevant county office.

(1) Exclusions: This procedure does not include:

(a) complaints that can be pursued through a fair hearing; and

(b) some mail issuance complaints: for example, if a recipient complains of nonreceipt of coupons through the mail, the procedures for replacement of coupons lost in the mail are followed; however, if the complaint concerns the mailing system, (staggered issue, use of certified mail, etc.) the complaint is handled through the complaint procedure.

(2) Filing: No special format is necessary for an individual to file a complaint. Instead, the complainant is encouraged to lodge a complaint by telephone (using HCA's toll-free number), through the mail, or in person. If a complainant needs help lodging the complaint, an ISS provides this help.

(3) Response: A complainant receives a response to their complaint within 10 days after receipt of the complaint.

(4) Public information: ISD personnel give information regarding the complaint system and civil rights complaints to all program recipients, applicants, and other interested persons. Such information is provided to clients during interviews, included in brochures, and publicized by posters displayed in all ISD offices.

D. Bilingual services: The state provides bilingual outreach materials and staff. This service is provided to households without an English-speaking adult. If a recipient has limited literacy or comprehension of English, the HCA employee provides, in a language understood by the recipient, an explanation containing the following elements:

(1) that the information requested is needed to determine eligibility for assistance;

(2) the consequences of providing incorrect or incomplete information;

(3) that changes in circumstances must be reported to HCA according to specific program changes;

(4) the consequences of failure to report changes;

(5) that HCA takes appropriate legal and administrative steps to recover overpayments which result from incorrect, incomplete or late reporting of information;

(6) a list of all information or changes which must be reported;

(7) monthly or other periodic reporting requirements.

[8.100.100.16 NMAC - Rp 8.100.100.16 NMAC, 7/1/2024]

8.100.100.17 BENEFIT ISSUANCE SYSTEM:

A. Electronic benefit transfer (EBT): SNAP and cash benefits are issued through a direct deposit into an EBT account. The benefits are maintained in a central database and accessed by the household through an individual debit card issued to the household.

B. Initial issuance of EBT card: The EBT card is issued to the designated payee of the eligible household or to the designated authorized representative.

(1) The EBT card is mailed to the head of household or the designated authorized representative on the first working day after the application is registered. The applicant or recipient shall receive training on the use of the EBT card prior to activation of the EBT card.

(2) The EBT card shall be issued to the payee for an eligible household through the most effective means identified by HCA which may include issuance at the county office or by mail.

(3) The applicant or recipient must verify their identity.

(4) The payee for the eligible household may select the four-digit personal identification number that will allow access to the household's benefits.

C. Replacement of the EBT card**:** The recipient or designated authorized representative shall be instructed on the procedure for replacement of an EBT card that has been lost, stolen or destroyed.

(1) The recipient or designated authorized representative may report a lost, stolen or destroyed EBT card through the HCA EBT contractor customer service help desk, HCA EBT customer service help desk or any ISD field office.

(2) The lost, stolen, or destroyed EBT card shall be deactivated prior to a replacement card being issued to the household.

(3) ISD shall make replacement EBT cards available for client to pick up or place the card in the mail within two business days following notice by the household to ISD that the card has been lost, stolen or damaged.

(4) ISD may impose a replacement fee by reducing the monthly allotment of the household receiving the replacement card, however, the fee may not exceed the cost to replace the card.

D. Excessive replacement cards: The HCA office of inspector general (HCA OIG) will generate a warning letter to SNAP recipients that have replaced their EBT card five or more times in a 12 month period. The letter is a notice of warning and will explain that as a result of the recipient's high number of replacement EBT cards, their EBT SNAP transactions will be closely monitored. The letter will become part of the recipient's case record. The letter will:

(1) be written in clear and simple language;

(2) meet the language requirements described at 7 CFR 272.4(b);

(3) specify the number of cards requested and over what period of time;

(4) explain that the next request, or the current request if the threshold has been exceeded, requires contact with ISD before another card is issued;

(5) provide all applicable information on how contact is to be made in order for the client to comply, such as whom to contact, a telephone number and address; and

(6) include a statement that explains what is considered a misuse or fraudulent use of benefits and the possibility of referral to the fraud investigation unit for suspicious activity.

E. Inactive EBT accounts: EBT accounts which have not been accessed by the recipient in the last 90 days are considered a stale account. HCA may store stale benefits offline after notification to the household of this action.

(1) The notification to the household shall include the reason for the proposed action and the necessary steps required by the recipient to reactive the account.

(2) The recipient may request reinstatement of their EBT account anytime within 364 days after the date of the last benefit account activity.

F. EBT benefit expungement: When benefits have had no activity:

(1) **SNAP**: HCA may expunge benefits that have not been accessed by the household after a period of 274 days. HCA must attempt to notify the household prior to expungement. Expunged benefits are no longer available to the household. Requests for reactivation must be received prior to expungement and a determination shall be made by the director or designee of the income support division.

(2) Cash: Cash assistance benefits which have had no activity for an excess of 180 days will be expunged. All benefits older than 180 days in the account will no longer be accessible to the household. The household loses all rights to all expunged benefits. The department shall attempt to notify the household no less than 45 days prior to the expungement of the cash assistance benefits.

[8.100.100.17 NMAC - Rp 8.100.100.17 NMAC, 7/1/2024]

8.100.100.18 TRAINING:

A. General statement: Effective staff development and training is an integral part of successful ISD program operations. ISD supports employee attendance at job-relevant training opportunities. Attendance at training sessions needs supervisory approval. Priorities for such approval are:

(1) training to improve skills needed in an employee's current position;

(2) training to add new skills useful in an employee's current position;

(3) training for an employee's career development.

B. **Budget:** ISD managers are encouraged to develop training plans and budgets for their administrative units. Such plans must be coordinated with the ISD training staff. ISD training staff members are available for consultation in developing these plans and budgets.

[8.100.100.18 NMAC - Rp 8.100.100.18 NMAC, 7/1/2024]

8.100.100.19 ADMINISTRATIVE TRAINING:

A. Personnel: New employees: ISD encourages prompt attendance at new-employee orientation sessions and requires completion of these sessions as specified in the division's training plan(s).

B. Professional development: ISD supports attendance at training sessions for an employee's professional development needs and goals. Such attendance requires supervisory review and approval and must not interfere with timely performance of an employee's ongoing duties.

[8.100.100.19 NMAC - Rp 8.100.100.19 NMAC, 7/1/2024]

8.100.100.20 PROGRAM TRAINING:

A. New employee training: The division maintains a new-employee training curriculum for all major programs administered by ISD. This program is accessible to all division and HCA employees who need training in food stamps, financial assistance or medical assistance programs.

B. Training standards: ISD training programs conform to the following standards:

(1) Needs assessments: Training programs are developed based upon generally accepted methods of training needs assessment, for example; formal analysis, training needs survey, performance statistics.

(2) Objectives and skills: Training developed and presented by ISD staff must be objective or competency based.

(3) Agenda and prior notification: Training provided to ISD staff members by other HCA employees must, at a minimum:

(a) be planned in advance with enough notice to adjust work schedules;

(b) have a written agenda;

(c) be coordinated with the ISD training staff.

(4) Training event report: All individuals who provide individual training sessions to ISD staff must complete an ISD training event report and submit the form to the ISD training staff.

[8.100.100.20 NMAC - Rp 8.100.100.20 NMAC, 7/1/2024]

8.100.100.21 PROVIDER TRAINING: Provision of training sessions - The ISD training staff provides program training to providers on request as scheduling permits.

[8.100.100.21 NMAC - Rp 8.100.100.21 NMAC, 7/1/2024]

8.100.100.22 SECURITY:

A. Physical property: It is the responsibility of each ISD county director or bureau chief to develop and maintain plans for ensuring the security office equipment, furniture and facilities according to department and other state and federal government guidelines.

B. Personnel security: ISD staff are provided training in tools and techniques to reduce the incidence or likelihood of violence or threats directed towards the ISD employee.

[8.100.100.22 NMAC - Rp 8.100.100.22 NMAC, 7/1/2024]

8.100.100. 23 ITINERANT SERVICES:

A. ISD provides itinerant service to clients residing at a distance from local ISD offices. Income support specialists visit specified locations on a regularly scheduled basis and conduct required interviews.

B. Itinerant schedules are available through local ISD offices. An itinerant location may not be eliminated by ISD without public notice and adequate justification.

[8.100.100.23 NMAC - Rp 8.100.100.23 NMAC, 7/1/2024]

History of 8.100.100 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD Rule 100, Program Descriptions, 2/9/1988.
ISD Rule 131, Administrative Policy, 2/10/1988.
ISD Rule 141, Treatment of Clients, 2/9/1988.
ISD Rule 141, Treatment of Clients, 6/18/1990.
ISD Rule 150, Confidential Information, 2/9/1988.

History of Repealed Material:
8 NMAC 3.ISD.000, 8 NMAC 3.ISD.010, 8 NMAC 3.ISD.020, 8 NMAC 3.ISD.030, 8 NMAC 3.ISD.050, 8 NMAC 3.ISD.060, General Administration and 8 NMAC 3.ISD.100, General Operating Procedures - Repealed, 7/1/1997.
8.100.100 NMAC, General Operating Procedures, (filed 3/26/2001)- Repealed effective 7/1/2024.

Other: 8.100.100 NMAC, General Operating Procedures, (filed 3/26/2001)- Replaced by 8.100.100 NMAC, General Operating Procedures, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 110 GENERAL OPERATING POLICIES - APPLICATIONS

8.100.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.110.1 NMAC - Rp 8.100.110.1 NMAC, 7/1/2024]

8.100.110.2 SCOPE: The rule applies to the general public.
[8.100.110.2 NMAC - Rp 8.100.110.2 NMAC, 7/1/2024]

8.100.110.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. 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.

[8.100.110.3 NMAC - Rp 8.100.110.3 NMAC, 7/1/2024]

8.100.110.4 DURATION: Permanent.
[8.100.110.4 NMAC - Rp 8.100.110.4 NMAC, 7/1/2024]

8.100.110.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.100.110.5 NMAC - Rp 8.100.110.5 NMAC, 7/1/2024]

8.100.110.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.110.6 NMAC - Rp 8.100.110.6 NMAC, 7/1/2024]

8.100.110.7 DEFINITIONS: [**RESERVED**]
[8.100.110.7 NMAC - Rp 8.100.110.7 NMAC, 7/1/2024]

8.100.110.8 RIGHT TO APPLY: Each individual shall have the opportunity to apply for public assistance programs administered by the HCA or to have an authorized representative do so on their behalf. Paper application forms must be readily accessible in the ISD local office lobby and provided to any person who requests the form. Applications are made in a format prescribed by the HCA to include paper forms or electronic submissions. All forms and notices will be accessible to individuals with limited-English proficiency or disabilities. ISD will post signs in local field offices which explain the application processing standards and the right to file an application on the day of initial contact.

A. Screening: Every applicant shall have the opportunity to meet, face to face or telephonically, with ISD when an application is submitted during regular business hours. ISD will review the application, assist the applicant in completing the application, if it is incomplete or assistance is

otherwise necessary, and will assist in identifying the public assistance program(s) for which the applicant wishes to apply.

(1) Screening for supplemental nutrition assistance program (SNAP) expedited service: ISD will screen SNAP applicants for entitlement to expedited processing, using the standard formula and documenting the application, at the time the household requests assistance.

(a) If the applicant is eligible for expedited service, the SNAP application will be processed in accordance with 8.139.110.16 NMAC.

(b) If expedited SNAP processing is denied, the applicant will be informed of the right to request an agency review conference to be held within two days of the request unless the household requests a later date pursuant to Paragraph (4) of Subsection E of 8.100.970.10 NMAC.

(2) Proof checklist: ISD shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of ISD's responsibility to assist the household in obtaining required verification provided the household is cooperating with ISD as specified in 7 C.F.R. 273.2(d)(1) and Section F of 8.139.110.11 NMAC. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in 7 C.F.R. 272.4(b). At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover.

(3) Scheduling the appointment: ISD must schedule an interview for all applicant households who are not interviewed on the day their application is received by ISD. An interview should be held within 10 working days from the date the application is received by ISD and, to the extent possible, convenient for both the applicant and ISD. To the extent practicable, ISD must schedule the interview to accommodate the needs of groups with special circumstances, including working households. ISD must schedule all interviews as promptly as possible to ensure eligible households receive an opportunity to participate within 30 days after the application is filed. ISD will send an appointment letter for an interview that includes contact information for ISD, date, time and place of the appointment. ISD must notify each household that misses its interview appointment that it missed the scheduled interview and that the household is responsible for rescheduling a missed interview. If the household contacts ISD within the 30-day application processing period, ISD must schedule a second interview. ISD may not deny a household's application prior to the 30th day after application if the household fails to appear for the first scheduled interview. If the household requests a second interview during the 30-day application processing period and is determined eligible, ISD must issue prorated benefits from the date of application.

B. Alternative interviews: Specific requirements for telephone and out of office interviews are outlined in each program's chapter on this topic.

C. Screening applications received by alternative means: ISD will screen applications for all public assistance programs and for expedited SNAP eligibility which includes applications received by alternative means. Alternative means include mail, fax, online, electronic transmission, or through an authorized representative.

[8.100.110.8 NMAC - Rp 8.100.110.8 NMAC, 7/1/2024]

8.100.110.9 SUBMISSION OF FORMS: Applicants may submit forms to a local county office in person or through an authorized representative, through the approved HCA web portal, by fax or by mail. The date the application and forms are received by ISD will be documented on the form. Applications submitted after regular business hours shall be considered received after business hours.

A. Incomplete application: An applicant has the right to file an incomplete form as long as the form contains the applicant's name, address and the signature of a responsible household or benefit group member or the household or benefit group's authorized representative, if one is designated.

B. Requesting application forms: When ISD receives a request for an application for assistance, ISD will mail, fax or hand deliver a paper application and provide the approved web portal address (for online applications), as indicated by the requestor, on the same day the request is received.

C. ISD shall provide households that complete an on-line electronic application in person at the ISD office the opportunity to review the information that has been recorded electronically and provide them with a copy of that information for their records, upon request.

[8.100.110.9 NMAC - Rp 8.100.110.9 NMAC, 7/1/2024]

8.100.110.10 INTERVIEWS: Specific requirements for the interview are outlined in each program's chapter on this topic. Related verification issues for the interview are located in the verification section.

[8.100.110.10 NMAC - Rp 8.100.110.10 NMAC, 7/1/2024]

8.100.110.11 PROCESSING APPLICATIONS:

A. Cash Assistance (CA)/SNAP combined cases: To facilitate participation in SNAP, the Food Stamp Act requires that individuals applying for CA be able to apply for SNAP benefits at the same time.

(1) Application: A household applying jointly for CA and SNAP is required to file only one application on a form

prescribed by ISD. The application contains the information necessary to complete the application process whether it was submitted by paper format or electronically online. If it is unclear to ISD whether the applicant intends to apply for SNAP, ISD will ask the applicant during the CA interview or other contact may be made with the applicant. An application for SNAP will be processed in accordance with time standards and procedures set forth in federal and state laws and regulations governing SNAP, including expedited processing provisions.

(2) Single interview: Whenever possible, a single interview will be held with an applicant who applies jointly for CA and SNAP benefits.

(3) Categorical eligibility: A SNAP household that meets criteria set forth in 8.139.420.8 NMAC is categorically eligible. If a household does not meet SNAP eligibility criteria, but is potentially categorically eligible, ISD must postpone denying the SNAP application until the 30th day.

(4) Application processing: Shall be processed in accordance with 7 C.F.R 273.2 j(1)(iv). As a result of differences in CA and SNAP application processing procedures and timeliness standards, eligibility for SNAP benefits may be determined prior to CA eligibility determination. Action on a SNAP application may be postponed until categorical eligibility is established to afford the household any benefits of this provision. However, SNAP approval may not exceed the applicable SNAP expedited or regular application processing timeliness standards.

(5) Application is denied: If a CA application is denied, an applicant is not required to file a new SNAP application. SNAP eligibility will be determined on the basis of the original application filed jointly for CA and SNAP, as well as any other documentation and information obtained in the course of the CA determination that is relevant to SNAP eligibility and benefit amount. A SNAP application may not be denied based on a CA denial reason, but must be based on the SNAP eligibility criteria.

(6) Denial retrieval: A SNAP application that is denied on the 30th day must be readily retrievable for another 30 days, in case the household is later determined eligible for CA or supplemental security income (SSI) benefits. When this occurs, ISD will use the original SNAP application, update any information and approve the SNAP case with prorated benefits as of the date of CA or SSI approval or payment effective date, whichever is later. A second interview is not necessary, however, the applicant or authorized representative should initial all changes and sign and date the verification of the changes.

B. Reporting changes: All participants in public assistance programs administered by the HCA are required to report any changed circumstances that relate to their eligibility for assistance or level of benefits. Each participant is provided with a list of the specific information they are required to report and the reporting time limits. When a change is reported, ISD must ensure that adjustments are made in the client's eligibility status or allotment for those months that the reported change is in effect, in accordance with each program's chapter on this topic.

(1) Notice: Whenever a client's benefits are altered as a result of changes, or whenever a certification period is shortened to reflect changes in the household's circumstances, the client is notified of the action by ISD in accordance with the notice requirements found in 8.100.180.10 NMAC and 8.100.180.11 NMAC. If the certification period is shortened, the household's certification period may not end any earlier than the second month following the month ISD determines the certification period should end. This allows adequate time to send a notice of expiration and for the household to timely reapply. If CA benefits are terminated, but the household is still eligible for SNAP benefits, members of the household must be informed about SNAP employment & training and ABAWD requirements, if applicable.

(2) CA reduction or termination within SNAP certification period: Whenever a reported change results in the reduction or termination of a client's CA benefits within the SNAP certification period, action will be taken to determine how the change affects the client's SNAP eligibility and benefit levels.

(a) Sufficient information: When there is sufficient information to determine how the change affects SNAP eligibility and benefit levels, the following actions will be taken:

(i) Reduction/termination of SNAP benefits: A change that reduces or terminates SNAP, CA or both benefits will generate a notice of adverse action for each category of assistance that is sent to the household and authorized representative. The notice(s) of adverse action will inform the household of its fair hearing rights and method for requesting continuation of benefits.

(ii) Increase in SNAP benefits: If the reduction/termination of CA benefits results in the increase of SNAP benefits, the increase in SNAP benefits occurs after the CA notice period expires and the CA grant is actually reduced or terminated.

(b) Insufficient information: Whenever there is insufficient information to determine how the CA change affects the client's SNAP eligibility and benefit level, the following actions shall be taken:

(i) CA notice of adverse action required: Where a CA notice of adverse action has been sent and the client requests a fair hearing and CA benefits are continued pending the appeal, the household's SNAP benefits will be continued on the same basis. However, the household must

recertify for SNAP benefits if the SNAP certification period expires before the fair hearing process is completed.

(ii) CA notice of adverse action not required: If a CA notice of adverse action is not required, or the client decides not to request a fair hearing and continuation of CA benefits, the household must be notified that its certification period will expire at the end of the month following the month the notice of expiration is sent, and that it must reapply if it wishes to continue to participate in the SNAP. The notice of expiration will also explain to the household that the certification period is expiring because of changes in its circumstances that may affect its SNAP eligibility and benefit level.

(3) Certification periods: ISD will assign CA and SNAP certification periods that expire at the same time. In no event are CA and SNAP benefits to be continued beyond the end of a certification period.

(4) Recertification: Households in which all members are contained in a single CA grant or in a single general assistance (GA) grant will have their SNAP interviews for recertification, to the extent possible, at the same time they are redetermined for CA.

(5) Reopened cases: If the CA and SNAP cases are closed or the SNAP certification expires, and the former recipient reapplies for one or both programs for the month following closure or expiration, benefits are prorated from the date of application for SNAP. If reapplication is made for CA or SNAP or both, following a break of one full month or more, SNAP and CA benefits for the month of application will be determined prospectively under beginning month provisions.

C. Other processing standards:

(1) SSI Households: Households in which all members are applying for SSI benefits are handled in the same manner as CA households with respect to the postponement of SNAP approval or denial and the retrieval of denied SNAP applications.

(a) Since ISD cannot monitor the progress of the SSI application, and if the SNAP application is denied on the 30th day, the household must be advised to reapply for SNAP when it has been notified of SSI approval.

(b) SSI households are also entitled to apply for SNAP and be recertified at the social security administration (SSA) offices. SSA will accept the application and forward the completed application, transmittal form, and any available verification to the designated local ISD field office. When SSA accepts and refers the application, the household is not required to appear at a second office interview, although ISD may request additional verification or information needed to make an eligibility determination. Processing time limits begin when the SNAP application is registered at the SSA office.

(2) GA households: Households in which all members are applying for state administered GA are to be processed jointly for GA and SNAP benefits. However, since these households are not, nor will they become categorically eligible, the provisions to postpone approval or denial and to retrieve denied SNAP applications do not apply.

(3) Mixed households: Households in which some but not all of the household members are applying for NMW benefits will file separate applications for CA and SNAP benefits. Applications will be handled under the same processing provisions required for nonfinancial assistance households. However, if those not applying for CA benefits are recipients of SSI, the SNAP application would be jointly processed, because SSI recipients are already considered CA recipients.

(4) Application processing standards joint applications other than CA/SNAP: Each type of benefit applied for will be processed according to its specific procedures and timeliness standards. No benefit's processing will be delayed waiting for other benefit's requirements.
[8.100.110.11 NMAC - Rp 8.100.110.11 NMAC, 7/1/2024]

8.100.110.12 TIME LIMITATIONS: A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.100.130.11 NMAC. These deadlines ensure that eligibility decisions are made promptly without restricting the applicant's right to supply verification of eligibility factors throughout the application processing period.
[8.100.110.12 NMAC - Rp 8.100.110.12 NMAC, 7/1/2024]

History of 8.100.110 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD Rule 170, FA/FS Combined Cases, 2/9/1988.

History of Repealed Material:
8 NMAC 3.ISD.110, General Operating Policies, Applications - Repealed, 7/1/1997.
8.100.110 NMAC - General Operating Policies - Applications (filed 3/26/2001) Repealed, effective 7/1/2024.

Other: 8.100.110 NMAC - General Operating Policies - Applications (filed 3/26/2001) Replaced by 8.100.110 NMAC - General Operating Policies – Applications, effective 7/1/2024

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 120 GENERAL OPERATING POLICIES - CASE MANAGEMENT

8.100.120.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.120.1 NMAC - Rp 8.100.120.1 NMAC, 7/1/2024]

8.100.120.2 SCOPE: The rule applies to the general public.
[8.100.120.2 NMAC - Rp 8.100.120.2 NMAC, 7/1/2024]

8.100.120.3 STATUTORY AUTHORITY:
A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.
B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.
C. 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.
[8.100.120.3 NMAC - Rp 8.100.120.3 NMAC, 7/1/2024]

8.100.120.4 DURATION: Permanent.
[8.100.120.4 NMAC - Rp 8.100.120.4 NMAC, 7/1/2024]

8.100.120.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.100.120.5 NMAC - Rp 8.100.120.5 NMAC, 7/1/2024]

8.100.120.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.120.6 NMAC - Rp 8.100.120.6 NMAC, 7/1/2024]

8.100.120.7 DEFINITIONS: [**RESERVED**]
[8.100.120.7 NMAC - Rp 8.100.120.7 NMAC, 7/1/2024]

8.100.120.8 CASE ASSIGNMENT: County directors are responsible for equitable and efficient assignment of assistance cases.
[8.100.120.8 NMAC - Rp 8.100.120.8 NMAC, 7/1/2024]

8.100.120.9 REVIEWS: County directors and ISS supervisors conduct case reviews as directed by their district operations managers.
[8.100.120.9 NMAC - Rp 8.100.120.9 NMAC, 7/1/2024]

History of 8.100.120 NMAC:
Pre-NMAC History: [**RESERVED**]

History of Repealed Material:
8 NMAC 3.ISD.120, General Operating Policies, Case Management - Repealed, 7/1/1997.
8.100.120 NMAC - General Operating Policies - Case Management - Applications (filed 3/26/2001) Repealed, effective 7/1/2024.

Other: 8.100.120 NMAC - General Operating Policies - Case Management - Applications (filed 3/26/2001) Replaced by 8.100.120 NMAC - General Operating Policies - Case Management - Applications effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 130 GENERAL OPERATING POLICIES - ELIGIBILITY AND VERIFICATION STANDARDS

8.100.130.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.130.1 NMAC - Rp 8.100.130.1 NMAC, 7/1/2024]

8.100.130.2 SCOPE: The rule applies to the general public.
[8.100.130.2 NMAC - Rp 8.100.130.2 NMAC, 7/1/2024]

8.100.130.3 STATUTORY AUTHORITY:
A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.
B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Chapter 9, Article 8 NMSA 1978 (Repl. 1983).
C. 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.
[8.100.130.3 NMAC - Rp 8.100.130.3 NMAC, 7/1/2024]

8.100.130.4 DURATION: Permanent.
[8.100.130.4 NMAC - Rp 8.100.130.4 NMAC, 7/1/2024]

8.100.130.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.100.130.5 NMAC - Rp 8.100.130.5 NMAC, 7/1/2024]

8.100.130.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.130.6 NMAC - Rp 8.100.130.6 NMAC, 7/1/2024]

8.100.130.7 DEFINITIONS: [**RESERVED**]
[8.100.130.7 NMAC - Rp 8.100.130.7 NMAC, 7/1/2024]

8.100.130.8 PRINCIPLES OF ELIGIBILITY: The income

support division (ISD) is responsible for administering food, cash, energy, and medical assistance programs. These programs are funded through federal or state sources and provide assistance to individuals who meet certain eligibility factors. State and federal regulations determine eligibility factors for each program. ISD determines if an individual qualifies for a program, and ensures that eligible individuals receive the assistance as quickly as possible and, in any event, within the application time frames for the applicable program.

A. Proof of eligibility: Determining eligibility for assistance requires that certain verification regarding an applicant/recipient's circumstances be made available to ISD. This verification is retained in the case record or noted in the case narrative.

(1) Applicant/recipient responsibility: The applicant/recipient is responsible to provide and obtain the verification necessary to determine eligibility.

(2) ISD responsibility: ISD is responsible for the following:

(a) to explain program participation requirements and the program specific eligibility factors to applicants/recipients;

(b) to explain the information and documents that must be provided to establish eligibility under each eligibility factor for a specific program;

(c) to offer and provide assistance in obtaining verification of an eligibility factor when the applicant/recipient indicates that verification may be difficult or costly to obtain; difficulty in obtaining verification may arise as a result of such circumstances as an applicant/recipient's limited ability to read, speak or understand the English language, mental impairments, physical illness, disability, lack of funds, lack of transportation or lack of knowledge about how to obtain the information; assistance by ISD includes explaining written information orally in the applicant/recipient's language, providing an interpreter, providing an address or telephone number of a person or agency, making telephone or written inquiries, allowing an applicant/recipient to use the telephone, locating a document, instructing an applicant in obtaining a document, requesting a document on behalf of an applicant/recipient or contacting a collateral contact; the assistance offered and provided is based on the particular needs of the applicant and ISD's ability to address those needs;

(d) to inform applicants/recipients in writing of their responsibility to provide necessary verification.

(3) Incomplete information: When available information is inconclusive, incomplete or indefinite, ISD shall be responsible for explaining, in writing, what questions remain and how they can be resolved. The explanation must make it clear that eligibility cannot be established without the information or documents and that failure to provide them shall result in denial, reduction or termination of assistance.

(a) The applicant/recipient shall also be informed they may reapply at any time but that the information, documentation or actions may affect the reapplication. If the applicant/recipient does not provide all of the verification needed, a decision shall be made to the extent possible, based on the existing verified information.

(b) For MAGI medicaid purposes, reasonable compatibility will be effectuated in accordance with 42 CFR 435.952.

(c) When assistance is denied, reduced, delayed or terminated due to failure to provide information or documents as requested, the case record must contain the explanation that such failure is the basis for the action. The client shall be informed in writing of the action.

B. Failure to provide verification: An applicant/recipient cannot be considered eligible for assistance until necessary verification is obtained. To the extent possible, ISD shall make eligibility determinations based on verified eligibility issues rather than failure to provide information.

C. Applicants/recipients may submit documentary evidence in person, by mail, facsimile, or other electronic device or through an authorized representative.
[8.100.130.8 NMAC - Rp 8.100.130.8 NMAC, 7/1/2024]

8.100.130.9 METHODS OF VERIFICATION:

A. Verification to determine eligibility and benefit level is obtained through six methods. Not all methods will necessarily be used in each case. The six methods are outlined in Subsections B through G of this section as well as the circumstance in which they may be used.

B. Prior case data not subject to change: Verification of an eligibility factor not subject to change which previously has been verified is accepted. At the application interview, ISD shall advise the applicant/recipient of any eligibility factors which have previously been established through documents in ISD's possession and that are not subject to change. ISD shall not require further verification of any eligibility factors already established. Such factors include: U.S. citizenship, permanent residency, birth date, relationship, social security enumeration and deprivation due to the death of a parent.

C. Electronic data: Every applicant/recipient shall be informed that the information provided is subject to verification through federal, state, local and contracted data systems. ISD shall review the information received from the data source with the applicant/recipient and not require additional verification of such information unless it is disputed by the applicant/recipient, the information is otherwise questionable, or the information does not comply with specific

benefit requirements. Questionable information is defined in 8.100.130.12 NMAC. Electronic data checks are automatically made and are not considered to be collateral contacts. The electronic data checked includes, but is not limited to:

(1) SSA and SSI information through the beneficiary data exchange (BENDEX) and the state data exchange (SDX) systems:

(a) the household shall be given an opportunity to verify the information from another source if the SDX or BENDEX information is contrary to the information provided by the household or is unavailable;

(b) eligibility and benefit level determination shall not be delayed past the application processing standards of 8.100.130.11 NMAC of this part if SDX or BENDEX data is unavailable;

(2) wage data and unemployment compensation benefits (UCB) through the interface with the New Mexico department of workforce solutions (NMDWS) - unemployment insurance database;

(3) interest, dividends, unearned income and self-employment wages through interfaces with the BENDEX wage data and internal revenue service (IRS) available through income and eligibility verification systems (IEVS):

(a) if the IEVS-obtained information is questionable, this information shall be considered unverified upon receipt and ISD shall take action to request verification of the information;

(b) except as noted in this paragraph, prior to taking action to terminate, deny or reduce benefits based on IEVS-obtained information, ISD shall request verification of the information;

(4) vehicle registration and driver's license information available from the New Mexico motor vehicle division; and

(5) child support payment information and absent parent information available from the child support services division.

(6) Restrictions: Information on earnings, benefits, resources and absent parents disclosed through government data systems shall be used only for the purpose of:

(a) verifying an applicant/recipient's eligibility;

(b) verifying the proper amount of benefits;

(c) investigating to determine whether recipients received benefits to which they were not entitled; and

(d) substantiating information which will be used in conducting criminal or civil prosecution based on receipt of benefits to which recipients were not entitled.

D. Documentary evidence: ISD shall use documentary evidence as the primary source of verification for all items except residency and household size. These items may be verified either through readily available documentary evidence, collateral contact or data from federal, state, local or contracted data sources, without a requirement being imposed that documentary evidence must be the primary source of verification. Documentary evidence consists of a written confirmation of a household's circumstances. Although documentary evidence shall be the primary source of verification, acceptable verification shall not be limited to any single type of document and may be obtained through the household or other source. Whenever documentary evidence cannot be obtained or is insufficient to make a determination of eligibility or benefit level, the eligibility worker may require collateral contacts or home visits. ISD is responsible for obtaining verification from acceptable collateral contacts. If a collateral contact is not available, a sworn statement shall be accepted from the household. ISD shall provide applicants/recipients with receipts for verification documents provided.

E. Collateral contacts: A collateral contact is an oral or written confirmation of a household's circumstances by a person outside the household. ISD shall document the reason for utilizing a collateral contact in the case file.

(1) A collateral contact can be used only when the applicant/recipient selects a collateral contact as the source of verification and:

(a) ISD cannot verify using a trusted electronic source;

(b) the applicant/recipient indicates difficulty in obtaining acceptable documentary evidence; or

(c) the documentary evidence provided by the applicant/recipient is inadequate or questionable.

(2) Selection of a collateral contact: The applicant/recipient and ISD shall select a mutually agreed upon collateral contact. A collateral contact must have knowledge of the applicant/recipient's circumstances and must be able to give accurate third party information.

(a) ISD may select a collateral contact only if the household fails to designate one or designates one who lacks knowledge of the applicant/recipient's circumstances or cannot give accurate information. If the applicant/recipient does not agree to the collateral contact and does not designate an acceptable collateral contact, the application may, in appropriate circumstances, be denied for failure to verify.

(b) A collateral contact shall not be rejected solely based on the following criteria:

(i) they are related to the applicant/recipient;

(ii) they are a recipient of public assistance; or

(iii)

they do not have a telephone.

(3) Failure on the part of a collateral contact: ISD shall not deny or delay an eligibility decision solely because of failure of a collateral contact to provide information. ISD shall decide the applicant/recipient's eligibility and benefit amounts based on all readily available information.

F. Home visits: Home visits may be used as verification only when electronic data or documentary evidence is insufficient to make a firm determination of eligibility or benefit level, or cannot be obtained. Home visits shall be selected as a method of verification with the applicant/recipient's consent. ISD shall schedule the home visit with the applicant/recipient in advance during normal business hours. ISD shall document the reason for the home visit in the case record.

G. Sworn statements:

(1) If the applicant/recipient has an immediate need for assistance, ISD shall accept and, if necessary, assist the applicant/recipient to identify necessary factors to be included in the statement, an applicant/recipient's sworn statement to verify one or more eligibility factors when there is:

(a) a reasonable explanation as to why electronic data documentary verification or a collateral contact is not readily available to establish the factors; and

(b) the applicant/recipient's statement does not contradict other credible information received by ISD; in such instances where the statement contradicts the other information, ISD may require additional verification within a reasonable time after approval and authorization of assistance: an applicant/recipient who objects to such an additional request for information shall have the right to request and receive a fair hearing.

(2) A sworn statement is defined as the applicant/recipient's statement signed under penalty of perjury.

[8.100.130.9 NMAC - Rp 8.100.130.9 NMAC, 7/1/2024]

8.100.130.10 SELECTION OF VERIFICATION: Verification shall be requested only when necessary to establish a specific eligibility factor or benefit amount for a program and is not available or acceptable from an electronic source, in accordance with other benefit requirements. The method of verification which is selected to establish eligibility on a factor is determined through discussion between ISD and the applicant/recipient.

A. Only necessary verification: ISD shall only request verification which is necessary to establish eligibility or benefit amounts for the assistance program(s) for which the applicant/recipient has applied.

B. Ready availability: The determination that verification is readily available will be made through discussion with the applicant/recipient. A readily available document is one which can be obtained by the applicant/recipient within five working days and at no cost to the applicant/recipient.

C. Verification of a negative statement: Verification, other than by sworn statement, of a negative statement shall not be required unless the statement is or becomes questionable as defined in 8.100.130.12 NMAC and at least one specific method of verifying the statement is readily available. A negative statement is a statement by an applicant/recipient that something does not exist or did not occur. Negative statements may be discussed with the applicant/recipient depending on the applicant/recipient's circumstances.

D. Verifying more than one factor: To the extent possible, ISD shall use a document to establish more than one eligibility factor.

[8.100.130.10 NMAC - Rp 8.100.130.10 NMAC, 7/1/2024]

8.100.130.11 TIMEFRAME FOR PROVISION OF VERIFICATION: An applicant/recipient is always allowed the complete time processing deadline for the program to provide necessary verification. The minimum amount of time allowed is specific to the program. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. Below are the time frames for provision of verification by type of assistance. ISD shall make an eligibility decision within three work days of the receipt of all necessary verification.

A. Food assistance and NMW/EWP cash assistance programs: The application disposition deadline for SNAP and cash assistance programs is 30 calendar days.

(1) Expedited (emergency) SNAP: If applicant is eligible for expedited SNAP processing, issue benefits no later than the sixth day following the date of application to be available to the applicant/recipient on the seventh day or the preceding work day if the sixth day falls on a weekend or holiday.

(2) Day 1: Calendar day following date of application.

(3) Approvals: If verification provided establishes eligibility and the 30th calendar day after the application is:

(a) Monday by the preceding Friday, the 27th day;

(b) Tuesday by the preceding Monday, the 29th day;

(c) Wednesday by the preceding Tuesday, the 29th day;

(d) Thursday by the preceding Wednesday, the 29th day;

(e) Friday by the preceding Thursday, the 29th day;

(f) Saturday by the preceding Friday, the 29th day;

(g) Sunday by the preceding Friday, the 28th day;

(h) Monday holiday by the preceding

Friday, the 27th day;

(i) if necessary verification is not received by these deadlines but is received on or before the end of the processing period, approve on the day that full verification is provided.

(4) Need-based determination: ISD must make a need-based eligibility determination for SNAP within 30 days of the date of the application or by the preceding work day if the 30th day falls on a weekend or holiday, if all mandatory verification has been received, with the following specific provisions. If one or more household members have failed to turn in mandatory individual verification that is not required for all the mandatory members of a household, ISD will deny those members missing verification, and will determine eligibility for the remaining members.

(5) Procedural denials:

(a) Lack of verification: In cases where ISD was able to conduct an interview and request all necessary verification on the same day or any day before the 30th day after the application was filed, and no subsequent requests for verification have been made, ISD may deny the application on the 30th day. Following the day of application, if ISD provided assistance to the household in obtaining the verification in accordance with 7 CFR 273.2(f)(5), but the household failed to provide the requested verification, ISD may deny the application on the 30th day after the application was filed.

(b) Missed interview: If the household failed to appear for a scheduled interview and made no subsequent contact with ISD to express interest in pursuing the application, the application shall be denied on the 30th day following the day of application. The household must file a new application if it wishes to participate in the program.

(6) Extension of time beyond the 30th day: If ISD does not determine a household's eligibility and provide an opportunity to participate within 30 days following the date the application was filed, ISD shall take action in accordance with 7 CFR 273.2(h).

(a) Household caused: If by the 30th day ISD cannot take any further action due to the fault of the household, the household shall lose its entitlement to benefits for the month of application and a notice of denial shall be issued. The household will be given an additional 30 days to take the required action.

(i) If the household takes the required action within 60 days following the date of application, the case shall be reopened without requiring a new application. If the household is found eligible during the second 30 day period, benefits shall be provided only from the month following the month of application. The household is not entitled to benefits for the month of application when the delay was the fault of the household.

(ii) If the household is at fault for not completing the application process within 60 days following the date of initial application, ISD shall deny the application and require the household to file a new application if it wishes to participate.

(b) ISD caused:

(i) Whenever a delay in the initial 30 day period is the fault of ISD, immediate corrective action shall be taken. If the household is found to be eligible during the second 30 day period, the household shall be entitled to benefits retroactive to the date of application. If, however, the household is found to be ineligible, ISD shall deny the application.

(ii) If ISD is at fault for not completing the application process by the end of the second 30-day period, and the case is otherwise complete, ISD shall continue to process the original application until an eligibility determination is reached.

(iii) If ISD is at fault for not completing the application process by the end of the second 30-day period, but the case is not complete enough to reach an eligibility determination, ISD may continue to process the original application, If ISD was also at fault for the delay in the initial 30 days, the amount of benefits lost would be calculated from the month following the month of application.

B. Medical assistance: As per 42 CFR 435.912 (c)(3), the determination of eligibility for any medicaid applicant may not exceed:

(1) 90 days for applicants who apply for medicaid on the basis of disability; and

(2) 45 days for all other medicaid applicants.

C. The 45-day processing timeframe is the following:

(1) Day 1: The date of application is the first day.

(2) No later than day 44 by the preceding work day if day 44 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if the day following day 44 is not a work day, then decision must be made earlier than day 44 to allow for mailing on or before the deadline.

(3) No later than day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is not provided until day 42 through 44.

(4) Day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is provided on day 45, or is not provided.

(5) After day 45:

(a) When an applicant/recipient requests one or more 10-day extensions of time to provide needed verification. An applicant/recipient is entitled to receive up to three 10-day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within three work days of receipt of all necessary

verification.

(c) HCA provides a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with 8.200.410.13 NMAC.

D. The 90-day processing timeframe is the following: An application for medicaid shall be processed no later than 90 days from the date the application is filed.

(1) No later than day 89: by the previous work day if day 89 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if day following day 89 is not a work day, then decision must be made earlier than day 89 to allow for mailing on or before deadline.

(2) No later than day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is not provided until day 87 through 89.

(3) Day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is provided on day 90, or is not provided. The eligibility decision must be made as soon as possible and within three-work days of receipt of all necessary verification.

E. **General assistance:** An application for general assistance shall be processed no later than 90 days from the date the application is filed.

(1) No later than day 89: by the previous work day if day 89 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if day following day 89 is not a work day, then decision must be made earlier than day 89 to allow for mailing on or before deadline.

(2) No later than day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is not provided until day 87 through 89. The only exceptions are days with system maintenance activities and network outage or down time.

(3) Day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is provided on day 90. The eligibility decision must be made as soon as possible and within three-work days of receipt of all necessary verification.

(4) If needed verification is not provided, case must be processed on day 90.

(5) Reconsideration: A reconsideration of a disability determination may be requested, verbally or in writing, by a client within 15 days of the date of the denial for not meeting conditions of disability. The reconsideration period shall not exceed 30 days from the date of denial. Disability will be evaluated based on additional medical evidence provided by the client during the reconsideration period. Should no request be made or the client does not provide additional medical evidence during the reconsideration period the denial shall remain and the client may reapply.

(6) Tracking the application processing time limit: The application processing time limit begins on the day after the signed application is received in the ISD county office.

(7) Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant/recipient shall be notified in writing of the reason for the delay and that the applicant/recipient has the right to request a fair hearing regarding ISD's failure to act within the time limits. Where applicable, NMAC subsections for specific programs detail how delays will be notified.

[8.100.130.11 NMAC - Rp 8.100.130.11 NMAC, 7/1/2024]

8.100.130.12 QUESTIONABLE INFORMATION/VERIFICATION:

A. To be considered questionable, incomplete or inadequate, the information or verification must be documented as one of the following:

(1) inconsistent with statements made by the applicant/recipient;

(2) inconsistent with other information on the application or previous applications;

(3) inconsistent with credible information received by ISD;

(4) questionable on its face.

B. Resolving questionable information: Upon receiving questionable, incomplete or inadequate verification needed to determine an applicant/recipient's eligibility or benefit amount, ISD shall promptly provide the applicant/recipient a notice which shall include the following:

(1) advise the applicant/recipient of the receipt of the information;

(2) why it is questionable, incomplete or inadequate;

(3) the additional information that must be provided;

(4) the alternative methods of providing the information,

(5) the deadline for supplying the information (10 working days or the end of the applicable application processing time period, whichever is later);

(6) that the applicant/recipient may discuss with ISD whether any other readily available verification is acceptable;

(7) that ISD is available to assist the applicant/recipient if the information is not readily available; and

(8) that a failure to supply the needed information or contact ISD by the deadline may result in a delay, a denial of eligibility, a reduction in the amount of benefits or termination of benefits.

[8.100.130.12 NMAC - Rp 8.100.130.12 NMAC, 7/1/2024]

8.100.130.13 NON-FINANCIAL VERIFICATION STANDARDS - IDENTITY:

A. SNAP and cash assistance programs: Verification of identity for the applicant is mandatory at application for the SNAP and cash assistance programs. Documents that can be used to verify identity for the SNAP and cash assistance programs include, but are not limited to:

(1) photo ID; including driver's license;

(2) birth certificate;

(3) school record;

(4) church record;

(5) hospital or insurance card;

(6) letter from community resources;

(7) voter registration card;

(8) work ID;

(9) ID for another assistance or social service program;

(10) wage stubs;

(11) additional items as listed in ISD 135, "proof checklist"; or

(12) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

B. Medical assistance programs: Verification of citizenship and identity for the applicant/recipient is mandatory at initial application. Acceptable documentary evidence of citizenship and identity is found at 8.200.410.12 NMAC in accordance with 42 CFR 435.407.

[8.100.130.13 NMAC - Rp 8.100.130.13 NMAC, 7/1/2024]

8.100.130.14 NON-FINANCIAL VERIFICATION STANDARDS: NONCONCURRENT RECEIPT OF ASSISTANCE:

A. Verification of nonconcurrent receipt of assistance is mandatory. ISD has responsibility for verifying nonconcurrent receipt of benefits usually through government data systems or other state agencies.

(1) For SNAP purposes, non-receipt of SNAP benefits from this state or another state or receipt of tribal commodities must be verified.

(2) For medicaid, ineligibility to receive medicaid benefits from this state or another state in the current month must be verified.

(3) For cash assistance, ineligibility for and non-receipt of assistance from the supplemental security income (SSI) program and bureau of Indian affairs general assistance (BIA GA) program, TANF assistance from New Mexico tribal programs, cash assistance from a HCA administered program and adoption subsidies funded through Title IV-E of the Social Security Act must be verified.

B. Non-receipt of benefits from another state must be verified for applicants who indicate a recent move to New Mexico from another state and prior receipt of assistance from that state.

C. Methods which can be used to verify nonconcurrent receipt of assistance include:

(1) ISD eligibility system for non-receipt of assistance from ISD programs;

(2) state data exchange (SDX) for non-receipt of SSI;

(3) contact with the New Mexico children, youth and families department for non-receipt of assistance;

(4) document from another state showing termination of benefits;

(5) collateral contact - oral statement from other state for termination of SNAP, TANF, or medicaid;

(6) collateral contact - oral statement from bureau of Indian affairs for non-receipt of BIA-GA; or

(7) collateral contact - oral statement from tribal TANF programs for non-receipt of tribal TANF.

[8.100.130.14 - Rp 8.100.130.14 NMAC, 7/1/2024]

8.100.130.15 NON FINANCIAL VERIFICATION STANDARD - ENUMERATION:

A. Verification that the enumeration requirement for an applicant/recipient has been met is mandatory for applicants who are seeking benefits for themselves unless the benefit program does not require enumeration, or the applicant seeking benefits is in an immigration status not requiring enumeration. The applicant/recipient must provide the social security number (SSN) which has been issued to the individual no later than 60 days following approval. ISD shall verify the SSN through the following methods:

(1) When an SSN is provided: The SSN will be verified through a data match with the SSA. If the SSN is not validated through the data match, the following sources of verification listed below may be utilized to validate the SSN:

(a) ISD eligibility system;

(b) social security card (OA-702);

(c) ISD social security number validation report form (ISD 260);

(d) an original SSA document containing the SSN; or

(e) the individual who has provided their SSN will not be required to produce proof of SSN unless the SSN is found to be questionable.

(2) When an SSN is not provided: The applicant/recipient must provide verification of application for an SSN. The verification must indicate an application was made prior to approval of the individual for assistance. The verification shall be retained in the case record. Documents that can be used to verify an application for SSN include:

(a) SSA 2853 enumeration at birth form;

(b) signed and dated statement from the hospital showing enumeration at birth has been done;

(c) original SSA document showing an application for SSN has been made and accepted; or

(d) completed SS-5; the completed SS-5 must be dated and submitted prior to the date of approved; a copy of the completed and submitted SS-5 must be retained in the case record.

B. There is no requirement of enumeration for medicaid-newborn (Category 31).
[8.100.130.15 - Rp 8.100.130.15 NMAC, 7/1/2024]

8.100.130.16 NON-FINANCIAL VERIFICATION STANDARD-CITIZENSHIP AND ELIGIBLE NON-CITIZEN STATUS: This section details the specific types of information and documents to be used in establishing the citizenship and non-citizen status for individuals who are applying for food assistance, cash assistance and medical assistance programs for themselves.

A. Citizenship for SNAP and cash assistance: Citizenship for SNAP and cash assistance programs will be verified only when questionable (as defined by 8.100.130.12 NMAC). Information and documents that can be used to verify citizenship include:

(1) social security number;

(2) birth certificate;

(3) naturalization papers from the department of homeland security United States citizenship and immigration services (DHS) such as DHS Forms I-179 or I-197;

(4) U.S. passport;

(5) military service papers;

(6) hospital record of birth;

(7) baptismal record, when place of birth is shown;

(8) Indian census records;

(9) DHS 400 for non-citizen children who can derive citizenship through citizen father or mother;

(10) additional items as listed on ISD 135, “proof checklist”;

(11) any document listed in Subsection B of this section; or

(12) if electronic verification is not available, and documentary evidence is not readily available, use other acceptable methods of verification as described in 8.100.130.9 NMAC.

B. Medical assistance programs: After July 1, 2006, an individual seeking medical assistance benefits for themselves must provide the income support division with a declaration signed under penalty of perjury that the applicant is a citizen, or a national of the United States, or is in an eligible immigration status. Applicants must present information allowing for verification of attested status. A non-citizen applicant who declares to be in an eligible immigration status is required to present immigration status information that can be used to verify attested status (such as an “A-number” or an “I-94 number”). Verification of citizenship for the applicant/recipient is mandatory at initial application. Acceptable documentary evidence of citizenship and identity is found at 8.200.410.12 NMAC in accordance with 42 CFR 435.407.

C. Non-citizen status: A non-citizen must have information allowing attested status to be verified.

D. Systematic alien verification for entitlement (SAVE):

(1) All applicants who attest to eligible immigration status will be subject to verification through the United States department of homeland security’s (USDHS) database (SAVE) system.

(2) Conflicting information regarding the citizenship status provided by the applicant/recipient will require additional verification by the USDHS.
[8.100.130.16 - Rp 8.100.130.16 NMAC, 7/1/2024]

8.100.130.17 NON FINANCIAL VERIFICATION STANDARDS - RESIDENCE:

A. Verification of New Mexico residence is mandatory. Residence may be verified by the use of documentary evidence provided for other eligibility criteria.

B. Documents that can be used to verify residency include:

(1) rent or mortgage receipt;

(2) statement from landlord;

(3) utility bills;

(4) statement from an employer;

(5) employment records;

(6) tax office records;

(7) post office records;

(8) church or synagogue records;

(9) utility company records;

(10) school records;

(11) proof of ownership of property;

(12) current driver’s license;

(13) canceled letters;

(14) additional items as listed on ISD 135, “proof checklist”; or

(15) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.
[8.100.130.17 - Rp 8.100.130.17 NMAC, 7/1/2024]

8.100.130.18 NON FINANCIAL VERIFICATION STANDARDS - HOUSEHOLD COMPOSITION:

A. The applicant/recipient’s statement regarding household composition will be accepted.

B. Household composition will only be verified when determined questionable as defined by 8.100.130.12 NMAC. Documents that may be used to verify household composition include:

(1) lease agreement listing household members;

(2) landlord's written statement of household composition;

(3) additional items as listed on ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other methods of verification as in 8.100.130.9 NMAC.

[8.100.130.18 - Rp 8.100.130.18 NMAC, 7/1/2024]

8.100.130.19 NON FINANCIAL VERIFICATION STANDARDS - AGE:

A. Age of child: Verification of age of children is mandatory for cash and medical assistance for children programs.

(1) For cash assistance: Age of the child is verified prior to approval.

(2) For medical assistance for children: Age of the child is verified to determine if the child is under the specified age limit**.**

B. Age of adults: Age of adult members is verified in the following circumstances if age is questionable:

(1) SNAP:

(a) if the individual is claiming a medical deduction on the basis of age (60 and over); or

(b) if the individual is working and income is being disregarded due to age (under age 18).

(2) Cash assistance:

(a) if the parent/caretaker relative is being considered for work program participation on the basis of being a minor parent and the parent claims to be age 20 or over;

(b) if the parent is living in their parent's home and is claiming emancipation on the basis of age (18 or over);

(c) if the parent/caretaker relative is not living in their parents' home and cooperation with child support enforcement is an issue due to age of the specified relative (under 18); or

(d) if the caretaker relative, parent or other adult member claims exemption from work program participation requirements based on age (60 and over).

(3) General assistance for the disabled:

(a) if the individual is claiming to be 18 or over and evidence is to the contrary; or

(b) if the individual is claiming to be under age 65 and evidence is to the contrary.

(4) Medical assistance for pregnant women:

(a) if the pregnant woman is living in her parent's home and is claiming emancipation on the basis of age (18 or over); or

(b) if the pregnant woman is under the age of 18 and is not living in her parent's home and cooperation with child support enforcement is an issue.

(5) Documents that can be used to verify age include:

(a) birth certificate;

(b) adoption papers or records;

(c) hospital or clinic records;

(d) church records;

(e) baptismal certificate;

(f) bureau of vital statistics records;

(g) U.S. passport;

(h) Indian census records;

(i) local government records;

(j) immigration and naturalization records;

(k) social security records;

(l) school records;

(m) census records;

(n) court support order;

(o) physician's statement;

(p) juvenile court records;

(q) voluntary social service agency records;

(r) insurance policy;

(s) minister's signed statement;

(t) military records;

(u) driver's license;

(v) additional items as listed on ISD-135, "proof checklist"; or

(w) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.19 - Rp 8.100.130.19 NMAC, 7/1/2024]

8.100.130.20 NON FINANCIAL VERIFICATION STANDARD - SCHOOL ATTENDANCE:

A. The statement of the parent, specified relative, or caretaker of school attendance for children under 18 years of age is acceptable to verify school attendance for the cash assistance program, unless questionable.

B. Verification of school attendance for all minor unmarried parents and dependent children over 18 years of age is mandatory for the cash assistance program. Documents that can be used to verify school attendance include:

(1) written statement from school official;

(2) current report card;

(3) additional items as listed on ISD 135, "proof checklist"; or

(4) if the preceding documentary evidence is not readily available, other acceptable methods of verification are set forth in 8.100.130.9 NMAC.

[8.100.130.20 - Rp 8.100.130.20 NMAC, 7/1/2024]

8.100.130.21 NON FINANCIAL VERIFICATION STANDARD - RELATIONSHIP:

A. Verification of relationship is mandatory in the cash assistance program. The relationship between the parent or other caretaker relative and each child included in the benefit group must be verified.

B. Documents that can be used to verify relationship include:

(1) birth certificate;

(2) adoption papers or records;

(3) Indian census records;

(4) bureau of vital statistics or local government records;

(5) DHS records;

(6) hospital or public health records of birth and parentage;

(7) baptismal records;

(8) marriage certificate showing legal marriage between parents;

(9) court records of parentage such as support orders, divorce decrees, etc.;

(10) juvenile court records;

(11) paternity records from CSSD;

(12) ISD acknowledgment of paternity form;

(13) CSSD acknowledgment of paternity packet for alleged or non-court ordered determined parents living with children;

(14) church records including a statement from a priest, minister, etc.;

(15) additional items as listed on ISD 135, "proof checklist"; or

(16) if documentary evidence is not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

C. The documentary evidence must contain the names of both the child and the specified relative. When the last name of the child differs from the specified relative, the difference must be resolved and documented in the case record. Divorce papers or marriage licenses can be used to help establish the relationship when the child's last name differs from the last name of the specified relative.

(1) If the relative is other than a parent, the relationship must be traced.

(2) In situations involving both parents in the home and the father is not the legal father, where paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the child to the father by completion of the CSSD acknowledgment of paternity packet.

(3) If the child is living with a relative of the alleged father, it will also be necessary to establish the father-child relationship. The preferred method of proving the relationship will be through acknowledgment of paternity, although other documents will be acceptable means of establishing relationship.

[8.100.130.21 - Rp 8.100.130.21 NMAC, 7/1/2024]

8.100.130.22 NON-FINANCIAL VERIFICATION STANDARDS - OTHER:

A. Fraud conviction for dual state receipt of benefits: The existence of a fraud conviction for simultaneous receipt of benefits from two states is determined based upon client statement on the application form. If ISD receives other information indicating the existence of a dual state benefit fraud conviction, ISD shall verify it by contacting the appropriate authorities.

B. Fleeing felon, probation or parole violator:

(1) Fleeing Felon: An individual determined to be a fleeing felon shall be an ineligible household member. To establish an individual as a fleeing felon ISD must verify that an individual is a fleeing felon. A federal, state, or local law enforcement officer acting in their official capacity must present an outstanding felony arrest warrant that conforms to one of the following national crime information center uniform offense classification codes, to the department to obtain information on the location of and other information about the individual named in the warrant:

(a) escape (4901); or

(b) flight to avoid prosecution, confinement, etc. (4902); or

(c) flight-escape (4999).

(2) Probation or parole violator: An individual determined a parole or probation violator shall not be considered to be an eligible household member. To be considered a probation or parole violator, an impartial party, as designated by ISD, must determine that the individual violated a condition of their probation or parole imposed under federal or state law and that federal, state, or local law enforcement authorities are actively seeking the individual to enforce the conditions of the probation or parole. Actively seeking is defined as:

(a) a federal, state, or local law enforcement agency informs ISD that it intends to enforce an outstanding felony warrant or to arrest an individual for a probation or parole violation within 20 days of submitting a request for information about the individual to ISD; or

(b) a federal, state, or local law enforcement agency presents a felony arrest warrant as provided in Paragraph (1) of Subsection B of this

section; or

(c) a federal, state, or local law enforcement agency states that it intends to enforce an outstanding felony warrant or to arrest an individual for a probation or parole violation within 30 days of the date of a request from ISD about a specific outstanding felony warrant or probation or parole violation.

(3) Certain convicted felons: An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(a) aggravated sexual abuse under section 2241 of title 18, United States Code;

(b) murder under section 1111 of title 18, United States Code;

(c) an offense under chapter 110 of title 18, United States Code;

(d) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or

(e) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(f) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

(4) Response time: ISD shall give the law enforcement agency 20 days to respond to a request for information about the conditions of a felony warrant or a probation or parole violation, and whether the law enforcement agency intends to actively pursue the individual. If the law enforcement agency does not indicate that it intends to enforce the felony warrant or arrest the individual for the probation or parole violation within 30 days of the date of ISD's request for information about the warrant, ISD shall determine that the individual is not a fleeing felon or a probation or parole violator and document the household's case file accordingly. If the law enforcement agency indicates that it does intend to enforce the felony warrant or arrest the individual for the probation or parole violation within 30 days of the date of ISD's request for information, ISD will postpone taking any action on the case until the 30-day period has expired. Once the 30-day period has expired, ISD shall verify with the law enforcement agency whether it has attempted to execute the felony warrant or arrest the probation or parole violator. If it has, ISD shall take appropriate action to deny an applicant or terminate a participant who has been determined to be a fleeing felon or a probation or parole violator. If the law enforcement agency has not taken any action within 30 days, ISD shall not consider the individual a fleeing felon or probation or parole violator, shall document the case file accordingly, and take no further action.

(5) Application processing: ISD shall continue to process the application while awaiting verification of fleeing felon or probation or parole violator status. If ISD is required to act on the case without being able to determine fleeing felon or probation or parole violator status in order to meet the time standards in 7 CFR 273.2(g) or 273.2(i)(3), ISD shall process the application without consideration of the individual's fleeing felon or probation or parole violator status.

[8.100.130.22 - Rp 8.100.130.22 NMAC, 7/1/2024]

8.100.130.23 FINANCIAL VERIFICATION STANDARDS - RESOURCES: The applicant/recipient's statement is acceptable for verification of resources unless the household is near the resource maximum limit and the information given is not questionable. If information is questionable, inconsistent or the household is near the maximum; ISD must clearly document why the household's statement was questionable in the case record and request additional verification. When further information or verification is requested the following items shall be acceptable:

A. Bank accounts (checking, savings, certificates of deposit, savings bond, or Keogh's). Documents which may be used to verify bank or financial institution accounts include:

(1) current bank statement;

(2) statement from the bank or institution showing the value of the resource or the penalties for early withdrawal of deposit showing the total value and the penalty for early withdrawal;

(3) savings bond(s) showing total value and statement from bank/institution of penalty for early withdrawal;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

(6) Joint bank accounts: see appropriate program chapter for proper verification requirements.

B. Stocks and bonds: Documents which may be used to verify the value of stocks or bonds include:

(1) newspaper publications of the stock exchange;

(2) statement from the stock broker;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. Life insurance: Documents which may be used to verify the cash surrender value of life insurance include:

(1) insurance policy;
(2) statement from the insurance company, insurance agent, lodges or fraternal organizations;
(3) statement from the union or employer who provide the insurance;
(4) statement from the veteran's administration;
(5) additional items as listed in ISD 135, "proof checklist"; or
(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC;
(7) if the cash surrender value of the life insurance policy makes the applicant/recipient ineligible, liens against the insurance shall be explored; this will be done through use of acceptable methods of verification set forth in 8.100.130.9 NMAC; the cash surrender value of life insurance is necessary in programs only where it is countable.

D. Real estate contracts, purchase contracts: Documents which may be used to verify the value of real estate or purchase contracts include:
(1) statement from a bank or financial institution, commodity broker, real estate agent, or expert in the field of real estate contracts or purchase contracts;
(2) additional items as listed in ISD 135, "proof checklist"; or
(3) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

E. Non-recurring lump sum payment: Documents which may be used to verify a nonrecurring lump-sum payment include:
(1) statement from a company, agency or organization that provided payment;
(2) copy of a check or check stub;
(3) award letters;
(4) statement from an attorney;
(5) additional items as listed in ISD 135, "proof checklist"; or
(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

F. Tools and equipment: Documents which may be used to verify the value of tools and equipment include:
(1) recent sales slips;
(2) insurance or tax appraisals;
(3) catalogs or newspaper ads;
(4) statement from a bank, broker, local merchant or expert on tools and equipment;
(5) additional items as listed in ISD 135, "proof checklist"; or
(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

G. Real property: Documents which may be used to verify the value of real property the applicant/recipient does not use include:
(1) a written statement from a real estate agent or broker stating the fair market value of property;
(2) statement from a bank or financial institution stating value and equity;
(3) additional items as listed in ISD 135, "proof checklist"; or
(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.
[8.100.130.23 - Rp 8.100.130.23 NMAC, 7/1/2024]

8.100.130.24 FINANCIAL VERIFICATION STANDARDS - UNEARNED INCOME: Verification of income is mandatory for all programs.

A. Social security benefits (OASDI, SSI): Documents which may be used to verify OASDI/SSI benefits include:
(1) award letter (Form SSA 1610);
(2) copy of a check(s) - amount of medicare premium must be added in;
(3) letter from SSA;
(4) direct deposit receipt - amount of medicare premium must be added in;
(5) additional items as listed in ISD 135, "proof checklist"; or
(6) if documentary evidence is not readily available or is questionable, a collateral contact with the social security administration (TPQY) may be selected as verification of OASDI/SSI or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Veteran's benefits: Documents which may be used to verify veteran's benefits include:
(1) award letter;
(2) copy of a check(s);
(3) written verification from a regional VA office;
(4) direct deposit receipt(s);
(5) additional items as listed in ISD 135, "proof checklist"; or
(6) if documentary evidence is not readily available or is questionable, a collateral contact with the veteran's administration may be selected as verification of veteran's benefits use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. Railroad retirement benefits: Documents which may be used to verify railroad retirement benefits include:
(1) award letter;
(2) copy of a check;

(3) letter from SSA;
(4) direct deposit receipt;
(5) additional items as listed in ISD 135, "proof checklist"; or
(6) if documentary evidence is not readily available or is questionable, a collateral contact with the regional director of retirement claims may be selected as verification of railroad retirement benefits or use acceptable methods of verification as in 8.100.130.9 NMAC.

D. Military allotments: Documents which may be used to verify military allotment include:
(1) written statement from the appropriate military service center;
(2) copy of the allotment authorization;
(3) copy of a check;
(4) direct deposit receipt;
(5) additional items as listed in ISD 135, "proof checklist"; or
(6) if documentary evidence is not readily available or is questionable, a collateral contact with the appropriate military service center may be selected as verification of a military allotment or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

E. Workers' compensation benefits: Documents which may be used to verify worker's compensation include:
(1) employer's statement;
(2) written statement from workers' compensation administration;
(3) written statement from insurance company;
(4) additional items as listed in ISD 135, "proof checklist"; or
(5) if documentary evidence is not readily available or is questionable, a collateral contact with the New Mexico department of workforce solutions (NMDWS) or with the insurance company may be selected as verification of workers' compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

F. Unemployment compensation benefits (UCB): Verification of unemployment compensation benefits should first be explored through the NMDWS web link. If it is not available through the NMDWS web link, the following documents may be used to verify UCB include:
(1) award letter;
(2) copy of a check;
(3) statement from the New Mexico DWS;
(4) additional items as listed in ISD 135, "proof checklist"; or
(5) if documentary evidence is not readily available, a collateral contact with the NMDWS may be selected as verification of unemployment compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

G. Child/spousal support: Verification of child or spousal support should first be explored through the CSSD automated system. If verification is not available through the CSSD system, documents which may be used include:
(1) written statement from the contributor;
(2) written statement from the court;
(3) copy of a check or a canceled check;
(4) divorce or separation decree;
(5) court order;
(6) support agreement;
(7) correspondence from the contributor regarding support payments;
(8) court records;
(9) attorney's records;
(10) income tax return from the prior year;
(11) employer's record of attached wages;
(12) additional items as listed in ISD 135, "proof checklist"; or
(13) if documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify child/spousal support or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC;
(14) no contact with the absent parent shall be made without the consent of the applicant/recipient. If good cause for failure to cooperate with CSSD has been filed, contact with the absent parent must not be made.

H. Educational scholarships, grants or loans: Documents which may be used to verify amounts of an educational scholarship, grant, or loan include:
(1) financial aid award letter or a budget sheet from the institution;
(2) written statement from the institution;
(3) written statement from veteran's administration;
(4) additional items as listed in ISD 135, "proof checklist";
(5) as educational expenses are deducted from the educational scholarship, grant or loan, it will be necessary to obtain verification of the expenses; verification may be obtained from the institution; or
(6) if documentary evidence is not readily available or is questionable, a collateral contact with the institution may be selected as verification of an education scholarship, grant or loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

I. Non-recurring lump sum: See Subsection E of

8.100.130.23 NMAC.

J. Contributions: Documents which may be used to verify contributions include:

(1) written statement from the contributor;

(2) additional items as listed in ISD 135, "proof checklist"; or

(3) if documentary evidence is not readily available or is questionable, a collateral contact with the contributor may be selected as verification of a contribution or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

K. Loans: Verification of a loan must contain the name of the person making the loan, the amount of the loan, date the loan was made and the repayment arrangement for the loan. Documents which may be used to verify loans include:

(1) written statement from the person or organization making the loan;

(2) promissory note;

(3) loan agreement;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available or is questionable, a collateral contact with the person or organization making the loan may be selected as verification of a loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

L. Individual development accounts (IDA):

(1) The IDA is verified by reviewing the trust documents creating the IDA and documents verifying deposits and withdrawals from the account during the period since the previous certification. The trust documents must show the terms and conditions governing the IDA, including withdrawal provisions.

(2) ISD shall review deposits and withdrawals to ensure that no funds are being withdrawn except for those allowed under IDA policy and to ensure that the individual was employed during the time that any deposits were made.

[8.100.130.24 NMAC - Rp 8.100.130.24 NMAC, 7/1/2024]

8.100.130.25 FINANCIAL VERIFICATION STANDARDS - EARNED INCOME:

A. Wages and salaries: Documents which may be used to verify current wages and salaries include:

(1) wage stubs;

(2) written statement from the employer;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available or is questionable, a collateral contact with the employer may be selected as verification of wages and salaries or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Self-employment: Verification of required tax and employer identification numbers, and tax-related and employer-related forms that the applicant/recipient was required to file is mandatory. It may not be possible to verify self-employment income through any single document. Documents which are used to verify self-employment income include:

(1) required state and federal tax and employer identification numbers;

(2) required federal and state tax forms for the current and prior tax year, including state and federal income and employer wage reporting and withholding reporting forms, gross receipts and occupation tax reporting forms;

(3) bills which indicate self-employment costs;

(4) other papers showing income and business expenses;

(5) all required business and occupation licenses;

(6) completed personal wage record;

(7) additional items as listed in ISD 135, "proof checklist"; or

(8) if documentary evidence of non-mandatory documents is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.25 NMAC - Rp 8.100.130.25 NMAC, 7/1/2024]

8.100.130.26 DEDUCTIONS/ ALLOWANCES VERIFICATION STANDARDS - SHELTER:

A. The applicant/ recipient's statement is acceptable for verification of shelter expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and what information requires additional verification. When further information or verification is requested the following items shall be acceptable:

(1) An obligation to pay for shelter is considered a deduction for SNAP. If the expense is questionable and verification of a shelter expense is requested and not provided, SNAP benefits will be determined without allowing a deduction for shelter expenses. When further verification is requested, documents which may be used to verify an obligation to pay for shelter include:

(a) mortgage payment book;

(b) written statement from the bank or other financial institution;

(c) rent receipt;

(d) written statement from the landlord;

(e) lease agreement;

(f) copies of bills for property taxes or house insurance;

(g) correspondence with the taxing

authority or insurance agency; or

(h) additional items as listed on ISD 135 "proof checklist".

(2) If documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify the obligation to pay shelter or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Utilities: The applicant/recipient's statement is acceptable for verification of utility expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and what information requires additional verification. Documents which may be used to verify an obligation to pay for utilities include:

(1) utility bills;

(2) rent receipt, lease agreement, or written statement from the landlord showing the household is responsible for payment of utilities;

(3) written statement from a utility provider;

(4) additional items as listed on ISD 135 "proof checklist"; or

(5) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.26 NMAC - Rp 8.100.130.26 NMAC, 7/1/2024]

8.100.130.27 DEDUCTIONS/ ALLOWANCES VERIFICATION STANDARDS - MEDICAL EXPENSES:

A. Verification of medical expenses is mandatory for SNAP if the applicant/recipient meets one of the criteria listed below. The applicant/recipient's statement that no reimbursement will be received will be accepted unless questionable. If the household claims a reimbursement, a deduction cannot be allowed until the un-reimbursed portion of the expense is verified.

(1) the individual claiming the medical expense is age 60 or older or disabled; and

(2) the amount of the medical expenses exceeds $35; or

(3) allowance of the medical expenses would potentially result in a deduction;

(4) failure to provide verification of medical expenses will result in a determination of eligibility and amount of benefits without considering medical expenses.

B. Documents which may be used to verify a medical expense include:

(1) current bill;

(2) monthly statement from the provider;

(3) medical insurance policy;

(4) appointment cards, travel receipts (lodging and transportation) to verify travel costs associated with obtaining medical care;

(5) additional items as listed in ISD 135 "proof checklist"; or

(6) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.27 NMAC - Rp 8.100.130.27 NMAC, 7/1/2024]

8.100.130.28 DEDUCTIONS/ ALLOWANCES VERIFICATION STANDARDS - DEPENDENT CARE:

A. The applicant/ recipient's statement is acceptable for verification of dependent care expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and why information requires additional verification.

B. Documents which may be used to verify dependent care costs:

(1) current bill;

(2) written statement from the provider;

(3) additional items as listed in ISD 135 "proof checklist"; or

(4) if documentary evidence is not readily available, or is questionable a collateral contact with the care provider may be used as verification of dependent care costs or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.28 NMAC - Rp 8.100.130.28 NMAC, 7/1/2024]

HISTORY OF 8.100.130 NMAC:

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History of Repealed Material:

8 NMAC 3.ISD.130, General Operating Policies, Eligibility/ Verification Standards, filed 6/16/1997 - Repealed, 7/1/1997.
8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, filed 3/26/2001 - Repealed, 8/1/2008.
8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, filed 7/17/2008 - Repealed NMAC effective, 7/1/2024.

Other: 8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, filed 7/17/2008 - Replaced by 8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards

effective, 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 150 GENERAL OPERATING POLICIES - RECORD RETENTION/ MANAGEMENT

8.100.150.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.150.1 NMAC - Rp 8.100.150.1 NMAC, 7/1/2024]

8.100.150.2 SCOPE: The rule applies to the general public.
[8.100.150.2 NMAC - Rp 8.100.150.2 NMAC, 7/1/2024]

8.100.150.3 STATUTORY AUTHORITY:
A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations…." It also provides for administration of public assistance programs.
B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.
C. 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.
[8.100.150.3 NMAC - Rp 8.100.150.3 NMAC, 7/1/2024]

8.100.150.4 DURATION: Permanent.
[8.100.150.4 NMAC - Rp 8.100.150.4 NMAC, 7/1/2024]

8.100.150.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.100.150.5 NMAC - Rp 8.100.150.5 NMAC, 7/1/2024]

8.100.150.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.150.6 NMAC - Rp 8.100.150.6 NMAC, 7/1/2024]

8.100.150.7 DEFINITIONS: [**RESERVED**]
[8.100.150.7 NMAC - Rp 8.100.150.7 NMAC, 7/1/2024]

8.100.150.8 RECORD RETENTION: Various records, forms and documents have differing periods of relevance and usefulness. Certain material in the record should be deleted on a scheduled basis when the material is no longer needed. To facilitate record management, as well as to establish the minimum period of time for which material must be retained, specific retention periods for case record materials have been established. Record retention schedules for each form are listed in the HCA forms manual table of contents.
[8.100.150.8 NMAC - Rp 8.100.150.8 NMAC, 7/1/2024]

8.100.150.9 RETENTION CODES:
A. P-retain permanently: Forms and documents must be retained in the case record permanently.
B. 4-retain four years: Federal regulations provide that fiscal documents must be retained for three years after the end of the period to which they apply. By retaining these records for four years, adjustment is made for post-closure reporting and audit periods within the federal requirements. If a record is part of a federal exception in an audit, the record is kept until the audit exception is resolved.
C. 1-retain one year: Many financial and medical assistance administrative forms, appointment letters, change notices, review schedules, etc., not needed for eligibility or benefit determination do not need to be kept for long periods of time, and can be destroyed when superseded or obsolete. Disposal of general correspondence not related to the eligibility conditions of clients is authorized when the purpose of the correspondence has been served.
D. SI-special instructions: There are some forms that can be destroyed when obsolete or no longer needed, or that are not filed in the case record. These forms have been identified under "SI" for reference purposes, and the user decides suitable disposition.
[8.100.150.9 NMAC - Rp 8.100.150.9 NMAC, 7/1/2024]

8.100.150.10 RETENTION OF NARRATIVE AND DOCUMENTS:
A. Narrative: All narratives are kept permanently.
B. Documents: Copies of documents such as court orders, medical information, birth certificates, social security cards, death certificates, contracts, etc., are filed in the record permanently.
[8.100.150.10 NMAC - Rp 8.100.150.10 NMAC, 7/1/2024]

8.100.150.11 RETENTION OF CORRESPONDENCE: Correspondence used to establish eligibility should be retained for four years. Correspondence not used to establish eligibility may be deleted after one year.
[8.100.150.11 NMAC - Rp 8.100.150.11 NMAC, 7/1/2024]

History of 8.100.150 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD Rule 131, Administrative Policy, 2/10/1988.

History of Repealed Material:
8 NMAC 3.ISD.150, General Operating Policies, Records Retention/Management - Repealed, 7/1/1997.

8 NMAC 3.ISD.150, General Operating Policies, Records Retention/Management, filed 7/1/1997 - Repealed effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 180 GENERAL OPERATING POLICIES - EXTERNAL COMMUNICATIONS

8.100.180.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.180.1 NMAC - Rp 8.100.180.1 NMAC, 7/1/2024]

8.100.180.2 SCOPE: The rule applies to the general public.
[8.100.180.2 NMAC - Rp 8.100.180.2 NMAC, 7/1/2024]

8.100.180.3 STATUTORY AUTHORITY:
A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.
B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.
C. 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.
[8.100.180.3 NMAC - Rp 8.100.180.3 NMAC, 7/1/2024]

8.100.180.4 DURATION: Permanent.
[8.100.180.4 NMAC - Rp 8.100.180.4 NMAC, 7/1/2024]

8.100.180.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.100.180.5 NMAC - Rp 8.100.180.5 NMAC, 7/1/2024]

8.100.180.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.180.6 NMAC - Rp 8.100.180.6 NMAC, 7/1/2024]

8.100.180.7 DEFINITIONS: [**RESERVED**]
[8.100.180.7 NMAC - Rp 8.100.180.7 NMAC, 7/1/2024]

8.100.180.8 COMMUNICATION WITH RECIPIENT - GENERAL COMMUNICATION: Both oral and written communications with applicants/recipients must be courteous. ISD shall inform the client promptly and in accord with state and federal regulations of actions relating to an application or ongoing case.
[8.100.180.8 NMAC - Rp 8.100.180.8 NMAC, 7/1/2024]

8.100.180.9 DENIAL/ APPROVAL OF APPLICATION: Prompt notification of action on a specific application is required. See specific program sections in this manual.
[8.100.180.9 NMAC - Rp 8.100.180.9 NMAC, 7/1/2024]

8.100.180.10 NOTICE OF AN ADVERSE ACTION: Before any action to withhold a cash assistance payment or to reduce or terminate medical, food stamp or cash assistance benefits, the HCA must issue timely and adequate advance notice of an adverse action.
A. Adverse action defined: Adverse action means an action taken by HCA that adversely affects eligibility or the amount of benefits a household or benefit group receives, including withholding, suspending, reducing or terminating benefits.
B. Timing: A notice shall be issued to the household or benefit group before taking an adverse action. Benefits will not be reduced until 13 days from the date on the adverse action notice. If the 13th day falls on a weekend or holiday, the next working day is counted as the last day of the 13-day adverse action notice period.
C. Contents:
(1) General: An adverse action notice shall contain, in easily understood language:
(a) reason for the proposed action, including the specific regulations supporting the action and the information on which the proposed action is based;
(b) date the action will take place;
(c) statement of the right to request a fair hearing and how to request a fair hearing;
(d) phone number of the caseworker in the event the client wants more information or wants to request a fair hearing;
(e) date by which the client must request a fair hearing to continue receiving assistance at the current rate;
(f) liability of the recipient for any overissuance or overpayment;
(g) right to be represented by legal counsel, friend or other spokesperson;
(h) notice that free legal help may be available to the household;
(i) the current benefit amount and proposed benefit amount after reduction for any reason.
(2) Specific:
(a) For a disqualification from participation in the food stamp program, the notice must also include the disqualification period, as appropriate, and the action the

disqualified individual must take to end ineligibility.

(b) For sanctions from cash assistance, the notice must also include the conciliation period, if applicable, and the sanction period, as appropriate, as well as the action the sanctioned individual must take to end ineligibility.

(c) For termination of cash assistance benefits due to reaching the TANF 60-month term limit, the notice must also include the actions the participant must take to apply for a hardship extension, found at 8.102.410.17 NMAC, and the availability of support services in the event the benefit group is not eligible for a hardship extension.

[8.100.180.10 NMAC - Rp 8.100.180.10 NMAC, 7/1/2024]

8.100.180.11 CONCURRENT NOTICE: A concurrent notice is one which is mailed no later than the date the benefit is or would have been received. It is also referred to as an adequate notice.

A. Food stamps: HCA notifies a household that its FS benefits are reduced or terminated no later than the date the household receives, or would have received, its allotment, in the following circumstances:

(1) the household reports the information which results in the reduction or termination;

(2) the reported information is in writing and signed by an adult household member;

(3) HCA can determine the household's allotment or ineligibility based solely upon the household's written information;

(4) the household retains its right to a fair hearing;

(5) the household retains its right to continued benefits by requesting a fair hearing within the time period provided by the adverse action notice;

(6) HCA continues (or supplements) the household's previous benefit level, if necessary, within five working days of the household's request for a fair hearing.

B. FA and medical: HCA notifies a benefit group that its benefits are reduced or terminated by no later than the date the group receives, or would have received, its benefit in the following circumstances.

(1) Death: Termination or reduction of assistance is necessary because of the death of an FA benefit group member or a MA recipient whose death is documented.

(2) Admission to institution: Reduction of assistance is necessary because the client enters a skilled nursing home or intermediate care facility, or termination is necessary because of the client's admission to an institution which makes him/her ineligible for payment.

(3) Client request: The client requests in writing that the FA or MA assistance be reduced or terminated; the client gives information in a signed statement that causes a termination or reduction of services and the client indicates in writing that the client understands this is the consequence of supplying such information.

(4) Whereabouts unknown: Withholding FA or MA assistance is necessary because of the unknown whereabouts of the client, as evidenced by agency mail to the client's last known address having been returned to the ISD as undeliverable.

(5) Other assistance: The client is accepted for FA or MA assistance in another county or state, or under another jurisdiction (including SSI) and the effective date of coverage has been established.

(6) Removal of child: Termination or reduction of FA is necessary because of the removal of a recipient child from the home through judicial determination or the voluntary placement of the child in foster care by the legal guardian or specified relative.

(7) Change in medical care: A change in a client's level of medical care is prescribed by their physician.

(8) Special allowance: A special allowance granted to a client for a specific period of time is terminated and the client has been informed at the time the allowance was granted that it would terminate at a specific time.

(9) Fair Hearings: An adverse action has been suspended pending a fair hearing and the fair hearing determination is not in the client's favor.

(10) Recertification: A recertification is not completed by the time the certification expires and a notice of suspension is issued, or the non-certified case has been in payment suspension for a month, and the case is being closed.

(11) Sanction: An FA payment is being reduced or terminated because an individual is not cooperating with the child support enforcement program or is failing to meet work program requirements.

(12) A client is also informed of their right to request a hearing on the action, the way to make such a request, and the conditions under which assistance will be continued if a hearing is requested. In any contact with the county office or in a hearing, the client may speak for themselves, or be represented by legal counsel or a friend or other spokesperson.

[8.100.180.11 NMAC - Rp 8.100.180.11 NMAC, 7/1/2024]

8.100.180.12 FOOD STAMP EXCEPTIONS: Adverse action notices are not required under the following conditions.

A. Mass changes: The state initiates a mass change.

B. Death: The ISS determines, based on reliable information, that all members of a household have died.

C. Move from project area: The ISS determines, based on reliable information, that the household has moved from the project

area, or will move before the next FS issue.

D. Completion of restoration of lost benefits: The client has been receiving an increased allotment to restore benefits, the restoration is complete, and the client has been previously notified in writing when the increased allotment would end.

E. Anticipated changes in monthly benefit amount: A household's allotment varies from month to month within the certification period to take into account changes which are anticipated at the time of certification, and the household was notified at the time of certification of the allotment variations.

F. Benefit reduction upon approval of household's FA application: The household jointly applied for FA and FS benefits, and has been receiving food stamps pending the approval of the FA grant, and was notified at the time of certification that FS benefits would be reduced upon approval of the FA grant.

G. Household member disqualified for intentional program violation: The benefits of the remaining household members are reduced or terminated to reflect the disqualification of a household member.

H. Benefits contingent upon providing postponed verification: The ISS has assigned a normal certification period to a household certified on an expedited basis, for whom verification was postponed, and the household was given a written notice that the receipt of benefits beyond the month of application was contingent upon its providing the required verification.

I. Conversion: Converting a household from cash or FS benefit recovery to recoupment (benefit reduction) because of failure to make agreed-upon repayment.

J. Loss of certification by drug or alcoholic treatment center or group living arrangement.: The ISS terminates the eligibility of a resident of a drug or alcoholic treatment center or a group living arrangement because the facility loses either its certification from the New Mexico health department or other appropriate state agency, or has its status as an authorized representative suspended because FCS has disqualified it as a retailer.

K. Transfer between FSP and food distribution programs: If a local office is notified by the appropriate Indian tribal organization (ITO) that a participating household wishes to switch programs, the ISS:

(1) advises the ITO of the earliest date that program transfer may occur without risk of dual participation;

(2) closes the FS case without advance notice; and

(3) follows up with the appropriate ITO-provided form.

L. Household requests termination:

[8.100.180.12 NMAC - Rp 8.100.180.12 NMAC, 7/1/2024]

8.100.180.13 FRAUD: If the agency obtains facts indicating that FA or MA should be suspended, terminated or reduced because of probable fraud by the recipient which has been verified, if possible, by collateral sources, notice of the action being taken is mailed at least five days before the action is to become effective.

[8.100.180.13 NMAC - Rp 8.100.180.13 NMAC, 7/1/2024]

8.100.180.14 CONTINUATION OF BENEFITS: If a fair hearing request is filed, benefits are continued, under the circumstances described below, until the fair hearing determination is completed.

A. Timely requests:

(1) Advance notice: If a household requests a fair hearing within the advance notice period provided by the advance adverse action notice, and its certification period has not expired, the household's participation in the program is continued on the same basis authorized immediately before the adverse action notice, unless the household specifically waives a continuation of benefits.

(2) All fair hearing request forms contain a space for a household to indicate whether or not continuation of benefits is requested. If the form does not positively indicate that the household has waived continuation of benefits, the ISS assumes that continuation of benefits is desired and the benefits are issued accordingly. Such benefits are continued until the end of the certification period or the resolution of the fair hearing, whichever is first.

B. Concurrent notice: If a benefit group requests a fair hearing within 13 days of issuance of a concurrent adverse action notice, and its certification period has not expired, cash assistance, food stamps and medicaid benefits are reinstated. Unless other intervening changes occur, assistance is not reduced or terminated, nor may the manner or form of payment be changed to a protective payment, during the period until the hearing decision is rendered, except as provided in regulations at 8.100.180.10 and 8.100.180.15.

(1) Additionally, receipt of continued benefits ends if a determination is made at the hearing that the sole issue is one of federal policy or law, or change in such policy or law, and not one of incorrect grant computation.

(2) If a later change affecting the client's grant occurs while the hearing decision is pending and the client does not request a hearing regarding the change, the payment which the client continues to receive during the hearing period is adjusted only by the amount required by the change.

(3) If assistance is to be continued, it is continued through the end of the month in which a decision on the hearing is reached.

(4) If hearing decisions are delayed, assistance is continued only if the delay is caused by HCA or if a delay of five days or less is requested by the client because of unusual circumstances beyond the client's control.

C. Late requests:

(1) If a hearing request is not made within the period provided by the adverse action notice, benefits are reduced or terminated as provided in the notice.

(2) If a client demonstrates that failure to make the request within the advance notice period was for good cause, benefits are reinstated to the previous level. The hearing unit supervisor decides if the failure was for good cause.
[8.100.180.14 NMAC - Rp 8.100.180.14 NMAC, 7/1/2024]

8.100.180.15 MASS CHANGES

A. General: Certain changes initiated by the state or federal government may affect the entire caseload or significant portions of it. These changes include, but are not limited to, increases or decreases in eligibility or payment standards changes in excluded or deducted items or amounts. Mass changes affecting income include annual adjustments of Social Security, SSI, and other federal benefit programs, and any other changes in eligibility criteria based on legislative or regulatory actions.

B. Notice of mass changes: Adverse action notices are required for mass changes resulting from statutory or regulatory changes in eligibility or payment standards, benefit, changes in excluded or deducted items or amounts for purposes of eligibility or calculation of benefit levels. The HCA will either provide concurrent notice to affected households of the mass change no later than the date the household receives, or would have received, its benefit issuance, or the affected cases will be notified through the media, and posters in county offices.

C. Appeal rights: Notice of the change will include the recipient's right to appeal. A hearing is not available, and benefits are not continued, when automatic benefit adjustments are required by federal or state law unless the specific, express basis for the hearing request is incorrect benefit computation. If the recipient requests a fair hearing within the advance notice period, benefits will be continued at the former amount. If the appeal results in a decision that the reduction or closure was incorrect, the difference between what the recipient received pending the appeal decision and the amount that should have been received will be restored to the recipient.
[8.100.180.15 NMAC - Rp 8.100.180.15 NMAC, 7/1/2024]

8.100.180.16 DISPUTED CONTINUATION OF BENEFITS: If a client and the ISS disagree about the continuation of benefits, the client may request a fair hearing. Adverse action defined. "Adverse action" is action taken by HCA which adversely affects the amount of benefits a client receives. Such actions include holding mailing of assistance warrants, and suspension, reduction or termination of benefits.
[8.100.180.16 NMAC - Rp 8.100.180.16 NMAC, 7/1/2024]

8.100.180.17 HOME VISIT NOTICE: The worker shall give advance notice to an applicant or recipient of any visit to the applicant's or recipient's home.

A. Verbal notice: The advance notice may be in the form of a verbal communication between the worker and the applicant or recipient. The time and date of the visit must be mutually agreeable and should, in most cases, be made at least one day in advance of the visit. The worker shall provide an explanation of the need for the visit to the applicant or recipient. The worker shall document the discussion in the case narrative and provide a justification if the period of advance notice is any less than one day.

B. Written notice: The home visit notice may be written. The written notice shall be mailed at least 10 days in advance of the intended visit. The notice shall indicate the time, date, and purpose of the visit. The notice shall request the applicant or recipient to confirm the appointment date with the worker. In the absence of a response from the applicant or recipient, the visit shall take place and the applicant or recipient is expected to be at home for the visit.
[8.100.180.17 NMAC - Rp 8.100.180.17 NMAC, 7/1/2024]

History of 8.100.180 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD Rule 180, Notice Requirements, 2/9/1988.

History of Repealed Material:
8 NMAC 3.ISD.180, General Operating Policies, External Communications - Repealed, 7/1/1997.
8.100.180 NMAC - General Operating Policies - External Communications (filed 3/26/2001) - Repealed effective 7/1/2024.

Other: 8.100.180 NMAC - General Operating Policies - External Communications (filed 3/26/2001) - Replaced by 8.100.180 NMAC - General Operating Policies - External Communications effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 390 GENERAL SUPPORT - INFORMATION SYSTEMS

8.100.390.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.390.1 NMAC - Rp 8.100.390.1 NMAC, 7/1/2024]

8.100.390.2 SCOPE: The rule applies to the general public.
[8.100.390.2 NMAC - Rp 8.100.390.2 NMAC, 7/1/2024]

8.100.390.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. 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.
[8.100.390.3 NMAC - Rp 8.100.390.3 NMAC, 7/1/2024]

8.100.390.4 DURATION: Permanent.
[8.100.390.4 NMAC - Rp 8.100.390.4 NMAC, 7/1/2024]

8.100.390.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.100.390.5 NMAC - Rp 8.100.390.5 NMAC, 7/1/2024]

8.100.390.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.390.6 NMAC - Rp 8.100.390.6 NMAC, 7/1/2024]

8.100.390.7 DEFINITIONS: [**RESERVED**]
[8.100.390.7 NMAC - Rp 8.100.390.7 NMAC, 7/1/2024]

8.100.390.8 FORMS ANALYSIS, DESIGN, MANAGEMENT

A. Official form defined: An official form is any form with the HCA logo and a number assigned in central office. An official form must include a statement as to the purpose of the form and instructions for completion, distribution, and retention of the form.

(1) All statements regarding participant rights and responsibilities which appear on forms must be exactly as they are in the policy manual.

(2) Forms used in ISD field offices will be indexed in the forms manual.

B. Forms covered by these procedures and forms not covered by these procedures: All forms used in ISD county offices and intended for public use are to be developed in accordance with these procedures. Forms intended for internal office use only may be developed by an office without using these procedures. Internal use forms are forms not sent out of the office and not used, received, or reviewed by program participants.

C. Sources for new and revised forms and pamphlets: New forms and pamphlets, and revisions to existing forms and pamphlets, may be proposed and developed by each division, as well as other HCA staff. In addition, the public information officer may also initiate new pamphlets and revisions to existing pamphlets in coordination with the appropriate program staff.

D. Assigning form numbers: Each division is responsible for developing its own forms numbering system. Numbering systems should appear in some reasonable order. It is recommended that this be done in the order in which forms are used in case processing. Sufficient space should be left between form numbers to allow for expansion of the system.

E. Responsibilities:

(1) Forms - program specific: The division, or program area responsible for the policy which is addressed by a form will have primary responsibility for the development and revision of the form. Each division will assign its own form numbers and maintain a log of its form numbers. A central log of all form numbers will also be kept by the graphics unit.

(2) ISD forms - program shared: Forms which are shared by more than one program and forms which do not involve any specific program will be assigned the suffix "ISD." The ISD form numbers log will be maintained by the ISD forms manager. The division or program area which proposes a new form or revision to an existing form will have primary responsibility for developing the new form or revising the existing form. The cost of producing the new or revised form will be prorated among the program areas which rely on the form. This proration will be based on caseload size.

(3) Forms - other sources: If the proposal for a new form or a revision comes from a field staff person or unit, the appropriate program, or division will review and approve the form prior to submission to the forms advisory team

(4) Pamphlets: Pamphlets should provide information and improve access to HCA programs. The most common purposes for the development of pamphlets are:

(a) HCA implements new programs;

(b) HCA makes significant policy changes; or

(c) auxiliary services are available.

(5) Responsibility for each pamphlet will reside with the which has primary responsibility for the policy issues addressed in the pamphlet. The unit which originates and develops the pamphlet will have responsibility for the distribution of the pamphlet within the HCA and elsewhere as required by the governing federal oversight agency. The public information officer will handle any other distribution of the pamphlet.

(6) All other situations: In the absence of clear responsibility, the forms advisory team will assign responsibility for the design and development of the new or revised form. The division forms manager is available for consultation on forms manual issues.

F. Forms review

procedures: All proposed new forms will be typed or printed in draft for review. Drafts of revisions to existing forms will be submitted on copies of the existing forms with changes marked clearly in red. Once the draft of the form and its instructions are complete, it may be necessary for the draft and instructions to be submitted to various agencies for review. Not all forms will be reviewed. Some will be reviewed in all four areas below and some will receive no review in these areas.

(1) Literacy review: All applications and forms pertaining to the eligibility process must be reviewed for appropriate literacy level. This will be accomplished by the office which develops the new form or revises an existing form.

(2) Review by general counsel: Any form to be sent to or completed by HCA clients or applicants must be reviewed by the HCA Office of general counsel in order to assure compliance with current legal standards. All drafts of pamphlets and informational items for general distribution to the public must also be reviewed by the office of general counsel before being sent to the public information officer for final approval.

(3) Approval by the public information officer: Following review by the office of general counsel, all drafts of pamphlets and informational items for general distribution to the public will be sent to the public information officer for final approval (see PIO-033.1).

(4) Review by inspector general: Forms authorizing certain payment, e.g. client medical travel expense, may also require review by the office of the inspector general. This requirement may change periodically. Those developing or revising forms of this nature should first consult with the OIG. Forms requiring review in any of these areas must be returned for re-review if any changes are made.

G. Forms advisory team review: After the new or revised form has been given all necessary review, the form and its instructions will be forwarded to the ISD forms manager. The forms manager will acknowledge receipt of the form and notify the primary program of the date of the review by the forms advisory team. A member of the program staff should be present when the forms advisory team meets to review the new or revised form.

(1) For new and revised forms, the forms advisory team will consider:

(a) Does the form address a new policy or program change?

(b) Does the form address a significant policy change?

(c) Is a form necessary or would clear procedural instructions meet the needs of implementation?

(d) If the form is necessary, is it user friendly and time efficient, and will it enhance the accuracy rate of the HCA?

(2) For revised forms, the forms advisory team will also require that one of the following three conditions be met:

(a) the current form no longer addresses all policy issues;

(b) the revision will streamline the user's completion of the form; or

(c) the revision is necessary to comply with audit/accountability/program policy requirements.

(3) Once the form has been reviewed and approved by the forms advisory team, it will be returned to the originating staff for submission to the graphics unit for printing.

[8.100.390.8 NMAC - Rp 8.100.390.8 NMAC, 7/1/2024]

8.100.390.9 GRAPHICS UNIT PROCESS:

A. The originating staff will complete a request/format approval form HCA 053 (green copy), attach the approved draft, and submit to the graphics unit. All drafts of proposed new forms submitted to the graphics unit must be typed or printed. The request/format approval form must include:

(1) quantity;

(2) dimensions;

(3) weight and type of paper;

(4) color of paper and inks;

(5) multiple copies;

(6) padding;

(7) stapling;

(8) drilling;

(9) stitching;

(10) wrapping;

(11) and any other special instructions.

B. The graphics unit will prepare a camera ready copy and contact the GSD state printing facility to obtain a price quote for the preparation of the procurement document. The graphics unit will return the price quote with the specifications to the originating staff who will prepare the procurement document. A copy of the camera ready will be reviewed, approved, and signed for by the originating staff. After approval and signature by the originating staff, the graphics unit will submit the camera ready to the GSD's state printing facility for printing. In some instances, camera readies may be copied at the HCA copy center. This decision will be made by the originating staff.

[8.100.390.9 NMAC - Rp 8.100.390.9 NMAC, 7/1/2024]

8.100.390.10 AUTOMATED FORMS: Forms that are generated by automated systems are controlled by the information systems bureau general supporting policy 8.100.390 NMAC.

[8.100.390.10 NMAC - Rp 8.100.390.10 NMAC, 7/1/2024]

8.100.390.11 HCA SUPPLY: For forms stored at the HCA central warehouse, originating staff should consult the warehouse manager to determine: inventory status of the

form; status of outstanding orders; and estimated date the form supply will be exhausted. This information will be used to determine the quantity of revised forms to be ordered and the revision date to be indicated on the revised form. The warehouse will notify the originating staff within 24 hours of receipt of the revised form/pamphlet. The originating staff will not release the form or pamphlet to the field offices until the warehouse has stock from which the field can order.
[8.100.390.11 NMAC - Rp 8.100.390.11 NMAC, 7/1/2024]

8.100.390.12 RELEASE OF MANUAL REVISION: Once notified by the warehouse that a supply of the new or revised form is available, the originating staff will prepare the manual revision cover memo. A copy of the completed manual revision, form, and instructions will be submitted to the ISD forms manager. The forms manager will update the forms manual indexes and submit the manual revision to the director's office for signature and numbering. The signed and numbered manual revision will be returned by the director's office to the originating staff for distribution to the field.
[8.100.390.12 NMAC - Rp 8.100.390.12 NMAC, 7/1/2024]

8.100.390.13 REORDERING FORMS: To re-order forms, the originating staff member fills out a form order/re-order memo and submits it to the warehouse manager for processing. The warehouse manager will complete the purchase document and return it to the program staff for signature.
[8.100.390.13 NMAC - Rp 8.100.390.13 NMAC, 7/1/2024]

8.100.390.14 DISCONTINUATION OF FORMS: If an originating staff member determines a form is to be discontinued and destroyed, the originating staff will first consult with the forms advisory team. When the discontinuation or destruction of a form is agreed on, the originating staff will fill out a form discontinuation memo and submit it to the forms manager for processing along with a copy of the manual revision deleting the form from the forms manual. This will ensure the updating of the index. The forms manager will then submit the documents to the warehouse manager.
[8.100.390.14 NMAC - Rp 8.100.390.14 NMAC, 7/1/2024]

History of 8.100.390 NMAC:
Pre-NMAC History: [**RESERVED**]

History of Repealed Material:
8 NMAC 3.ISD.390, General Support, Information Systems - Repealed, 7/1/1997.
8.100.390 NMAC - General Support - Information Systems (filed 3/26/2001) Repealed effective 7/1/2024.

Other: 8.100.390 NMAC - General Support - Information Systems (filed 3/26/2001) replaced by 8.100.390 NMAC - General Support - Information Systems effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 110 GENERAL OPERATING POLICIES - APPLICATIONS

8.102.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.110.1 NMAC - Rp 8.102.110.1 NMAC, 7/1/2024]

8.102.110.2 SCOPE: The rule applies to the general public.
[8.102.110.2 NMAC - Rp 8.102.110.2 NMAC, 7/1/2024]

8.102.110.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.110.3 NMAC - Rp 8.102.110.3 NMAC, 7/1/2024]

8.102.110.4 DURATION: Permanent.
[8.102.110.4 NMAC - Rp 8.102.110.4 NMAC, 07/01/2024]

8.102.110.5 EFFECTIVE DATE: July 1, 2024, unless a later

date is cited at the end of a section.
[8.102.110.5 NMAC - Rp 8.102.110.5 NMAC, 7/1/2024]

8.102.110.6 OBJECTIVE:
A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.
B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.110.6 NMAC - Rp 8.102.110.6 NMAC, 7/1/2024]

8.102.110.7 DEFINITIONS: [**RESERVED**]
[8.102.110.7 NMAC - Rp 8.102.110.7 NMAC, 7/1/2024]

8.102.110.8 GENERAL:
A. Application form: The application shall be submitted on a form designated by the HCA either electronically or in writing and is made under oath by an applicant with whom a dependent child resides. The HCA shall assist an applicant in completing the application for cash assistance or services. The application must contain a statement of the age of the child; residence; a statement of property in which the applicant has an interest; a statement of the income that the applicant or other benefit group members have at the time the application is filed; a signature under penalty of perjury from the applicant; and other information required by the HCA.
B. Interview:
(1) A face-to-face interview with the applicant shall be required in order to obtain information needed to the determine eligibility, verify, and record the facts supporting the application; and to give the applicant information about HCA programs and program requirements. When circumstances warrant, the household shall be interviewed by telephone or another place reasonably accessible and agreeable to by the applicant and the caseworker in accordance with 8.102.110.11 NMAC.
(2) The applicant must identify all individuals living in the residence whether or not the individuals are requesting assistance. The applicant and the HCA shall identify all individuals who must be included in the benefit group.
(3) Other information, documents, and collateral contacts may be required to determine eligibility. Requests for verification are made in accordance with provisions set forth in 8.100.130 NMAC.
C. Resource planning session: The applicant shall be provided a resource planning session no later than 30 days after an application is filed. The HCA shall attempt to provide a resource planning session prior to approving the application, but it is not mandatory. Failure to provide a resource planning session shall not impede registration or processing of the application. The focus of the resource planning session is to ascertain the applicant's immediate needs, assess the applicant's financial and non-financial options, and to provide general information about HCA assistance programs. The caseworker shall assist the applicant in exploring and accessing any other financial or non-financial options that may meet the benefit group's needs. If there is any indication that the applicant might be eligible for SSI, the relative advantages of the SSI program shall be explained and the applicant shall be referred to the local social security office.
D. EBT orientation: NMW cash assistance benefits shall be authorized and available through an electronic benefit transfer (EBT) account. The HCA shall provide EBT training to an applicant in order to be able to access cash assistance benefits.
E. Application processing time limit: An application for NMW cash assistance shall be processed no later than 30 days after an application is filed. No later than five days after the application is approved, a reimbursement for childcare shall be provided, subject to the appropriation and availability of state or federal funds.
[8.102.110.8 NMAC - Rp 8.102.110.8 NMAC, 7/1/2024]

8.102.110.9 RIGHT TO APPLY:
A. An individual has the right to make a formal application for any cash, food or medical assistance program administered by the HCA, regardless of whether the individual appears to meet the conditions of eligibility. Any individual requesting information or assistance, who wishes to apply for assistance, shall be encouraged to complete the application that same day. The individual shall be informed:
(1) of the right to apply, whether or not it appears the individual may be found eligible; and
(2) that the date of application affects the benefits.
B. Availability of applications: The HCA shall provide the YES- New Mexico web portal address to submit an application online or paper applications for cash assistance to anyone requesting an application, and to local agencies and organizations that have regular contact with the public. When the HCA receives a request for an application for assistance, the HCA will either mail or hand deliver a paper application, provide the web portal address for YES-New Mexico (for online applications), or provide both as indicated by the requestor.
[8.102.110.9 NMAC - Rp 8.102.110.9 NMAC, 7/1/2024]

8.102.110.10 SUBMISSION OF THE APPLICATION FORM:

A. Items completed: To be accepted and registered, the cash assistance application, at a minimum, must be submitted on a form designated by the HCA either electronically or in writing, identify the benefit group member applying, the program applied for, and have a signature of a responsible benefit group member or authorized representative.

B. Who completes the application: The application form must be completed by the applicant, an authorized representative, guardian, or another appropriate individual.

(1) Authorized representatives must be:

(a) designated in writing by the applicant/head of household; and

(b) be an adult who has sufficient knowledge about the applicant's circumstances to complete the application form correctly.

(2) If an authorized representative or another appropriate individual completes an application form, the applicant must review and approve the completed form. The applicant is liable for improper payments resulting from erroneous information given by the authorized representative or another appropriate individual.

(3) The caseworker may assist in completing the form if there is no one else to help the applicant.

(4) Application for minor children: Application for cash assistance for minor children, including unemancipated minor parents, must be made by the adult with whom the child resides and who is assuming responsibility for the support and care of the child.

(a) If a minor parent is living in a second-chance home, maternity home, or other adult-supervised supportive living arrangement, the application must be made by the supervising adult as the authorized representative for the minor parent.

(b) An emancipated minor may file an application in the emancipated minor's own right.

C. Signature:

(1) The application form must be signed by the applicant and authorized representative if one is designated. A signature means that the applicant is verifying the information provided by the household and has read and agrees with all of the statements on the application or other form requiring a signature. A signature is the depiction of the individual's name either, handwritten, electronic or recorded telephonically. Electronic and telephonically recorded signatures are valid only if provided in a format or on a system approved by the HCA, which includes verification of the identity of the person providing the signature.

(2) If an applicant receives help from someone other than a caseworker in completing the form, that individual must also sign at the bottom of the form.

(3) An individual who cannot sign the individual's own name must sign the application with a mark and have it witnessed. A mark, which is not witnessed, shall not be accepted as a valid signature. A caseworker may not witness signatures on an application the caseworker will be processing.

(4) If the application is made on behalf of a child, the form shall be signed by the relative or caretaker with whom the child is living, or by the authorized representative.

(5) If the individual, relative, or caretaker has a legally appointed guardian, the guardian must complete and sign the form.

D. Where filed: An application may be submitted to the HCA in person, by mail, via facsimile or by other electronic means which may include the YES-New Mexico web portal.

E. Incomplete applications: If an application is incomplete, prompt action shall be taken by the HCA to notify the applicant. The individual who completed the application form must add the missing or incorrect information and initial and date the entries. All reasonable action shall be taken by the HCA to avoid any unnecessary delay of the applicant's eligibility determination.

F. Out-of-state applicants: An application mailed in from out of state shall be accepted, but shall not be registered until the applicant contacts ISD to confirm presence in the state. If the applicant does not contact the ISD within 30 days, the application shall be returned to the applicant.

G. Application registration: Completed and signed in-state applications shall be registered effective the date on which the application is received during regular business hours; this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regular scheduled business hours, holidays and weekends will be considered received as of the next business day.

H. Tribal TANF programs: An application for NMW benefits received from an applicant residing in a tribal TANF service delivery area shall be accepted by ISD and registered as of the date the application was received during regular business hours. Applications that are dropped off or submitted electronically after regular scheduled business hours, holidays and weekends will be considered received as of the next business day.

(1) Effective upon implementation of a tribal TANF program, the applicant shall be required to apply for the tribal TANF program in the service delivery area in which the applicant resides.

(2) Prior to finalizing an application for NMW benefits received from an applicant residing in a tribal TANF service delivery area, the applicant shall be

informed he or she must apply for tribal TANF.

(a) The applicant shall be informed in writing that the applicant must provide verification of the disposition of the applicant's tribal TANF application.

(b) The applicant shall be referred to the appropriate tribal TANF service delivery area serving the community or county in which the benefit group lives.

[8.102.110.10 NMAC - Rp 8.102.110.10 NMAC, 7/1/2024]

8.102.110.11 INTERVIEWS:

A. Application interview: All applicants shall be interviewed in person at the local office or, when circumstances warrant, at another place reasonably accessible and agreeable to both the applicant and the caseworker. The applicant may bring any individual to the interview.

B. Alternative interviews:

(1) A cash assistance applicant shall not be required to have a face-to-face interview if the applicant is unable to appoint an authorized representative and the household has no member(s) able to come to the HCA due to one of the hardship conditions listed in Paragraph (2) of Subsection B of this section.

(2) Hardship conditions: The face-to-face interview for cash assistance households shall be waived when the applicant meets one of the following conditions:

(a) over the age of 60;

(b) disabled;

(c) employed 20 or more hours per week;

(d) has transportation difficulties;

(e) prolonged severe weather;

(f) other hardship identified as situations warrant; as authorized by the county director.

(3) A face-to-face interview must be granted to any recipient who requests one. If the recipient is unable to come to the office due to the issues listed in Paragraph (1) or (2) of this subsection, then an interview may be scheduled at a location agreed upon by the caseworker and the applicant.

C. Home visits: A home visit may be made to conduct the interview and obtain the information needed, as long as the HCA gives adequate prior notice of the visit.

D. Scheduling interviews: An interview shall be scheduled upon receipt of the application. The interview shall take place within 10 working days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant.

E. Missed interviews: The applicant shall be responsible for scheduling a second appointment. If the applicant does not contact the office or does not appear for the rescheduled interview, the application shall not be denied until the 30th calendar day (or the next workday if the 30th is not a workday) after the application was filed.

F. Purpose and scope of interview:

(1) Prior to approval there shall be an interview with the applicant. The purpose and scope of the interview shall be explained to the applicant. The interview is an official and confidential discussion of benefit group circumstances between the applicant and the caseworker. The interview allows the caseworker to explore and clarify unclear or incomplete information reported on the application and is intended to provide the applicant with information regarding the work program, child support benefits and requirements, the temporary nature of the program, eligibility requirements, and to provide the caseworker with the necessary facts to make an accurate eligibility determination.

(2) For cash assistance cases, at initial application, a brief history shall be required in the case narrative explaining the circumstances, which led to the application. The narrative shall include information clearly describing the child's situation with respect to child support from a non-custodial parent or parents.

G. Applicant information: During the course of the interview all reasonable steps shall be taken to make the applicant feel at ease and protect the applicant's right to privacy. The interviewer shall tell the applicant about the following:

(1) services available and requirements which must be met under the cash assistance program and the child support enforcement programs;

(2) school attendance and reporting requirements;

(3) complaint and hearing procedures;

(4) work program procedures;

(5) work requirements;

(6) application processing standards;

(7) procedures in cases of overpayment or underpayment;

(8) responsibility to report changes;

(9) non-discrimination policy and procedures;

(10) timeliness standards; and

(11) semiannual reporting requirements.

[8.102.110.11 NMAC - Rp 8.102.110.11 NMAC, 7/1/2024]

8.102.110.12 APPLICATION PROCESSING TIME LIMITS:

A. Timeliness: The caseworker shall explain time limits and the applicant's right to request an administrative hearing if the application is not processed within the applicable time limits.

B. Processing time limit: Cash assistance applications shall be completed within 30 calendar

days from the date of application.

C. "Clocking" of time limits: "Clocking" of time limits begins on the day after the date of application.

D. Delayed assistance: If an eligibility determination is not made within the required time limits, the applicant shall be notified in writing of the reason for the delay. The notice shall also inform the applicant of the applicant's right to request an administrative hearing regarding the issue of ISD's failure to act within the time limits.

[8.102.110.12 NMAC - Rp 8.102.110.12 NMAC, 7/1/2024]

8.102.110.13 DISPOSITION OF APPLICATION/NOTICE:

A. Denials: If an application is denied, ISD shall issue a written notice to the applicant of a denial. The denial notice shall include the date of denial, reason for denial, the regulation under which the denial was made, the applicant's right to a fair hearing concerning the denial, and the time limits for filing a fair hearing request. The notice shall also explain that the applicant may discuss the decision with the caseworker, supervisor, or county director.

B. Approvals: If the application is approved, the applicant shall be notified by mail or by electronic means which may include the YES-New Mexico web portal. The notice shall report the initial month of eligibility, amount of payment, how the payment is calculated, and the members who have been determined eligible.

C. Application withdrawal: An applicant may voluntarily withdraw the application at any time before eligibility determination. An effort shall be made to confirm the applicant's desire to withdraw the application. Applicants shall be advised that withdrawal of the application has no effect upon the right to apply for assistance in the future.

D. Tribal TANF requirements:

(1) If an applicant fails to provide documentation of denial for tribal TANF within 30 days, the NMW application shall be:

(a) held for 30 days beginning with the day after the date of application;

(b) denied on the 30th day or on the next business day if the 30th is not a business day.

(2) If the applicant provides documentation of denial for tribal TANF within 30 days, ISD shall determine the cause for denial prior to processing the NMW application. Applicants who verify denial of tribal TANF within 30 days shall be processed according to current NMW policy.

(a) An applicant denied tribal TANF benefits for the following reasons shall be immediately denied NMW cash assistance:

(i) failure to provide information;

(ii) failure to cooperate with the application process;

(iii) failure to comply with any tribal TANF non-financial eligibility criteria; or if

(iv) the benefit group is currently within a sanction period involving total benefit group ineligibility.

(b) Individuals qualifying for or receiving tribal TANF benefits shall be denied NMW cash assistance.

[8.102.110.13 NMAC - Rp 8.102.110.13 NMAC, 7/1/2024]

8.102.110.14 APPROVAL EFFECTIVE DATE: NMW cash assistance shall be approved effective the date of authorization or no later than 30 days following the date of application, whichever is earlier. Payment in the initial month shall be prorated from the date of authorization.

[8.102.110.14 NMAC - Rp, 8.102.110.14 NMAC, 7/1/2024]

8.102.110.15 ELECTRONIC CASE FILE:

A. Documents in paper format will be imaged into an electronic case file (ECF). The ECF is located within the automatic system program and eligibility network (ASPEN). ASPEN will digitize the volume of paper documents received from individuals and manage them electronically in a centralized repository.

B. Implementation of the electronic document management solution provides ISD the capability to administer and manage eligibility related processes and tasks.

C. Once the existing paper case files are imaged the electronic record will be considered the official record.

[8.102.110.15 NMAC - Rp 8.102.110.15 NMAC, 7/1/2024]

History of 8.102.110 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 210.0000, The Application Process for Financial and Medical Assistance, 2/22/1980.

ISD FA 210, Application Process, 2/9/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.110 NMAC General Operating Policies - Applications - Repealed, 07/01/2001.

8.102.110 NMAC General Operating Policies - Applications, (filed 6/18/2001) - Repealed effective 7/1/2024.

Other: 8.102.110 NMAC - General Operating Policies - Applications (filed 6/18/2001) replaced by 8.102.110 NMAC - General Operating Policies - Applications effective, 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES

CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 120 ELIGIBILITY POLICY - CASE ADMINISTRATION

8.102.120.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.120.1 NMAC - Rp 8.102.120.1 NMAC, 7/1/2024]

8.102.120.2 SCOPE: The rule applies to the general public.
[8.102.120.2 NMAC - Rp 8.102.120.2 NMAC, 7/1/2024]

8.102.120.3 STATUTORY AUTHORITY:
A. 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.
B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.
C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.
D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.
E. In close coordination with the NMW program, the HCA administers the supplemental nutrition assistance program (SNAP) employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.
F. 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.
[8.102.120.3 NMAC - Rp 8.102.120.3 NMAC, 7/1/2024]

8.102.120.4 DURATION: Permanent.
[8.102.120.4 NMAC - Rp 8.102.120.4 NMAC, 7/1/2024]

8.102.120.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.120.5 NMAC - Rp 8.102.120.5 NMAC, 7/1/2024]

8.102.120.6 OBJECTIVE:
A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.
B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.120.6 NMAC - Rp 8.102.120.6 NMAC, 7/1/2024]

8.102.120.7 DEFINITIONS: [RESERVED]
[8.102.120.7 NMAC - Rp 8.102.120.7 NMAC, 7/1/2024]

8.102.120.8 [RESERVED]

8.102.120.9 ELIGIBILITY REVIEWS:
A. Follow-up reviews:
(1) A follow-up review shall be scheduled during a certification period whenever information becomes known to the county office indicating a possible change in a benefit group's circumstances that may affect eligibility or payment amount.
(2) Review of a specific condition may be made by home visit, office visit, third party contacts or correspondence as needed.
(3) Circumstances which may require follow-up review include, but are not limited to:
(a) change in NMW participation work requirements;
(b) school attendance of children age six or older;
B. Recertification:
(1) Cash assistance shall be approved for a fixed certification period at the end of which the assistance shall be terminated.
(2) The recertification shall consist of a complete review of all conditions of eligibility; determination of eligibility for an additional period of time and redetermination of the amount of assistance payment. The recertification requires a redetermination of eligibility on those conditions that are subject to change. There shall be a prospective determination beginning the month following the month the certification expires.
(3) The caseworker shall ensure that CSSD has been notified of all pertinent information regarding any non-custodial parent who has a child in the benefit group, including but not limited to the current address and work place of the non-custodial parent.
(4) Conditions not subject to change: Unchanged

information shall not be re-verified unless it is incomplete, inaccurate, inconsistent, or outdated. Outdated is defined as unchanged verification that is more than 60 days old relative to the current month of participation.

(5) Work program: The caseworker shall give information to the NMW participants about earned income incentives, assistance through the transitional child care program, medicaid transitional benefits, and work program requirements, opportunities and services. Work program participation shall be reviewed.

(6) Need and payment determination: The caseworker shall obtain current information about family and benefit group:

(a) Income: if the source has changed or the amount has changed by more than $50;

(b) Resources: if the total of all countable resources for the benefit group exceed the $1500 liquid or $2000 non-liquid resource limit; and

(c) any other information which has changed or is questionable.

(7) Change reporting: The caseworker shall review with the client the possible changes in circumstances which must be reported if they occur.

(8) Providing verification:

(a) If electronic verification is not available, the household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information.

(b) ISD shall assist a household in obtaining verification, provided the household is cooperating in the application process.

(c) A household or their authorized representative may supply documentary evidence in person, by mail, fax, electronic device or through the YES NM web portal.

(d) A household shall not be required to supply verification in person at the ISD office or to schedule an appointment to provide such verification.

(e) ISD shall accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

(9) Recertification time standards:

(a) Timely reapplication: Applications filed before the 15th day of the expiration month will be considered timely. A household member or authorized representative that attends an interview and provides all necessary verification by the end of the household's current certification period, will have the opportunity to participate by the household's normal issuance cycle in the month following the end of the current certification period, if all eligibility factors have been met.

(b) Reapplication after the 15th: If an application for recertification is submitted after the 15th but before the end of a household's certification period and the household is determined eligible for the first month following the end of the certification period, that month is not considered an initial month and benefits are not prorated.

(c) Late applications: An application that is submitted to ISD after the certification period has expired can be accepted within 30 days after the certification period expires or the case has been closed for any reason. Initial month verification standards will be used for all applications received during this time frame and the benefits for a late recertification will be prorated from the date of approval.

C. Certification scheduling:

(1) Each case must have eligibility and payment reviewed at least once during the period specified for that category. Cash assistance cases, which also receive SNAP, shall be recertified at the same time the SNAP certification is completed.

(2) The certification period shall not exceed the following standards:

(a) Regular reporting benefit groups: A benefit group not subject to simplified reporting requirements shall be certified for:

(i) five months or less: education works program;

(ii) 12 months: state supplement for SSI recipients in residential care;

(iii) eight months from date of arrival: refugee resettlement program.

(b) Simplified reporting benefit groups: Certification provisions that apply to a NMW benefit group subject to simplified reporting are set forth at Subsection A of 8.102.120.11 NMAC.

D. Interview:

(1) All recertification interviews shall be in person at the local office or, when circumstances warrant, over the phone or at another place reasonably accessible and agreeable to both the recipient/relative or caretaker and the caseworker. The recipient may bring any individual to the interview.

(2) The interview must be with the recipient, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. See 8.100.130 NMAC for instructions on obtaining information.

(3) To help a recipient report changes that may affect the recipient's eligibility or amount of payment, the caseworker shall make available a change report form upon request, which the client may use to notify the county office of changes in circumstance.

E. Scheduling recertification reviews: The certification period end date shall be scheduled for the appropriate interval indicated in Subsection C

of 8.102.120.9 NMAC, starting with the initial month of eligibility, or the month following the month in which previous certification expired.

F. Exchange of information with SSA:

(1) If information received during any eligibility review indicates that a participant in NMW or GA may be eligible for supplemental security income (SSI) benefits, (this includes children and adults who appear disabled, and needy adults over 65), the caseworker shall promptly refer the participant to the social security administration district office for application. An individual found eligible for SSI must participate in that program.

(2) During the review process, ISD will sometimes learn information relevant to the eligibility of a family member who is a SSI recipient. If there is a clear indication that a SSI recipient's countable income exceeds the maximum allowable under the SSI program, the discrepancy shall be reported to the social security administration (SSA) district office. SSA shall also be notified when it appears that the resources of an SSI recipient exceed SSI program standards.

[8.102.120.9 NMAC - Rp 8.102.120.9 NMAC, 7/1/2024]

8.102.120.10 HANDLING BENEFIT GROUP AND RESIDENCE STATUS CHANGES:

A. Change of name or payee: Whenever there is a change in a participant's name or the payee for cash assistance, the caseworker shall immediately make the appropriate changes.

(1) New caretaker:

(a) If a new caretaker assumes responsibility for a dependent child in a case, the case shall be closed and a new application processed.

(b) If the new caretaker is already payee for other dependent children, the cash assistance case of the children being transferred to the new payee shall be closed, an add-on application shall be processed, and the children added to the existing benefit group.

(2) Payee change after benefits are issued: The EBT account shall be made accessible to another family member by authorization of a new PIN under the old account.

(3) Changes in name or payee are indicated when:

(a) a payee legally changes their name and the change has been processed through the social security administration;

(b) a legal guardian is appointed or dismissed;

(c) the parent of an incompetent adult client begins to serve as natural guardian; or

(d) there is a change of payee for an NMW grant.

B. Change in benefit group composition: A request for assistance for a new benefit group member shall be treated as add-on an application. An add-on application shall be processed using the timeliness and verification standards applicable to regular applications.

C. Move to another state: If a participant advises the county office in advance of the participant's departure from the state, the participant shall be contacted to determine whether the participant intends to:

(1) be out of the state for a temporary period with a plan to return once the purpose of the visit has been accomplished; or

(2) abandon residence in New Mexico;

(3) the caseworker shall cover the following points:

(a) whether the client wishes to continue receiving assistance out-of-state during a temporary absence;

(b) whether the client intends to apply for assistance in another state;

(c) how long the participant intends to be out-of-state;

(d) the purpose of the visit;

(e) whether a place of residence in New Mexico is being maintained in the participant 's absence.

(4) If it appears on the basis of this information that New Mexico residence is being abandoned, assistance shall be terminated. If absence is temporary, cash assistance shall be continued and the client must keep the HCA informed of the client's address and circumstances.

D. Illness: If a participant who is temporarily visiting outside New Mexico is unable to return to New Mexico because of illness, cash assistance may continue until such time as the participant is able to return. In this situation, the participant's inability to return to New Mexico because of illness must be verified by medical report.

E. DVR training: If plans are made in conjunction with DVR for a participant's participation in a training course in another state, cash assistance may be continued for the duration of the training course for the participant and the participant's dependents, if they accompany the participant, provided that the benefit group intends to return to New Mexico when training is completed.

[8.102.120.10 NMAC - Rp 8.102.120.10 NMAC, 7/1/2024]

8.102.120.11 SIMPLIFIED REPORTING: Simplified reporting (SR) is a periodic reporting requirement for benefit groups that receive NMW cash assistance. A benefit group assigned to SR must file an interim report form in the sixth month of a 12-month certification period.

A. Certification period:

(1) Initial application: A benefit group that is applying for both SNAP and NMW, shall be assigned a NMW certification period that ends in the same month as the SNAP certification period

with the exception of those SNAP benefit groups assigned to a 24-month certification.

(2) An initial applicant for NMW that is already participating and assigned to simplified reporting in the SNAP program:

(a) if approved for NMW, shall be assigned a NMW certification period that will end the same month as the SNAP certification period; and

(b) must file an interim report form in the same month that one is due in the SNAP program;

(c) if NMW is approved in the same month an interim report form is due in the SNAP program, the requirement in Subparagraph (b), above, is waived for NMW.

(3) A benefit group that is approved for NMW, but does not receive SNAP shall be assigned a twelve-month certification period:

(a) beginning the first month of eligibility; and

(b) shall have an interim report form due in the sixth month of the NMW certification period.

(4) A benefit group that is receiving NMW and applies for SNAP shall have NMW eligibility re-determined at the same time that the SNAP eligibility is determined.

(a) If NMW benefits increase, the increase shall be effective the month following the first month of approval for SNAP and NMW shall be assigned a certification period that ends in the month the simplified reporting SNAP certification ends.

(b) If approved for SNAP and the NMW benefit decreases, the decrease shall be effective the month following the month the NOAA expires, and the NMW benefit group shall be assigned a certification period that ends in the same month the SNAP certification ends.

(c) If approved for SNAP and the NMW benefit is terminated, the termination shall be effective the month following the month the NOAA expires, and the SNAP case shall be transitioned to TFS.

(5) Recertification: A benefit group that is recertifying and is approved and assigned to simplified reporting shall be assigned a certification period that:

(a) is 12 months long;

(b) begins the month after the current certification ends; or

(c) is set to end in the same month as a SNAP case with a common member.

B. Excluded from simplified reporting: The simplified reporting requirement shall be assigned to all NMW benefit groups except programs listed in Paragraph (2) of Subsection C of 8.102.120.9 NMAC.

C. Simplified reporting requirements: A benefit group assigned to simplified reporting shall be required to file an interim report form no later than the tenth day of the sixth month of the 12-month certification period, or in compliance with the SNAP simplified report, whichever is appropriate. The benefit group must include the following information along with necessary verification, as required at 8.100.130 NMAC:

(1) any change in benefit group composition, whether a member has moved in or out of the home along with the date, the change took place;

(2) a change in the source of income, including starting or stopping a job or changing jobs, if the change in employment is accompanied by a change in income;

(3) changes in either:

(a) the wage rate or salary or a change in full-time or part-time employment status as defined in Subsection C of 8.102.461.11 NMAC, provided the household is certified for no more than six months;

(b) a change if earned income of more than one hundred dollars ($100) a month from the amount last used to calculate the household's allotment, provided the household is certified for no more than six months.

(4) a change of more than $100 in the amount of unearned income;

(5) changes in countable resources if the total of all countable resources for the benefit group exceed the $1,500 liquid or $2,000 non-liquid resource limit;

(6) dependent care expenses;

(7) changes in residence, only if, there has been a change in residence since the last certification;

(8) changes in child support receipt; and

(9) changes in immigration status for a benefit group member.

D. Budgeting methodology for simplified reporting at initial application and recertification:

(1) Prospective budgeting shall be used for an applicant benefit group at initial application and at recertification as set forth at 8.102.500.9 NMAC.

(2) At initial application, eligibility and amount of payment for the applicant benefit group shall be determined prospectively for the each of the first six months of the certification.

(3) At recertification, eligibility and amount of payment shall be determined prospectively for six months following last month benefit group's certification period.

E. Budgeting methodology for simplified reporting:

(1) At processing the interim report form, eligibility and amount of payment shall be determined prospectively for the six months following the month the interim report form is due.

(2) In determining a benefit group's

eligibility and payment amount, the income already received shall be used to prospectively anticipate income the benefit group expects to receive during the certification period according to the following schedule:

(a) Weekly: For income received weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(b) Bi-weekly: For income received bi-weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(c) Semi-monthly: For income received semi-monthly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(d) Monthly: For income received monthly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(e) Income received more frequently than weekly: For benefit groups with income received more frequently than weekly, exact income, rather than averaged and converted income shall be used to determine benefits. For income received more frequently than weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(f) If a determination is made that the use of the pay data for the methods described in (a) through (e), above, does not give the most accurate estimate of monthly earnings due to unique circumstances; the caseworker shall use whatever method gives the most accurate estimate of earnings.

(g) Income received less frequently than monthly: The amount of monthly gross income that is received less frequently than monthly shall be determined by dividing the total income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It also includes contract income and income for a tenured teacher who may not have a contract.

(3) Self-employment:

(a) Requirements for determination of self- employment income are set forth at Subsection E of 8.139.520.10 NMAC, and the verification standards for business and self-employment income are set forth at 8.100.130.25 NMAC.

(b) A benefit group assigned simplified reporting that has had self-employment income annualized by ISD shall be required to report changes in self-employment income only if the benefit group has filed a tax return subsequent to its last approval or recertification for NMW.

(c) A benefit group assigned simplified reporting that does not have the self-employment income annualized must report self-employment income on the interim report form. The income reported on the simplified report form will be calculated in the following manner.

(i) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the duration of the certification period.

(ii) Seasonal income: Self-employment income that is intended to meet a benefit group's needs for only part of the year shall be averaged over the time the income is intended to cover.

(d) A benefit group required to report simplified self-employment income that fails to provide verification of an allowable deduction at the interim or during the month the interim report form is due shall not be allowed the deduction. ISD shall process the report if all other mandatory verification has been provided.

(4) Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(a) income received on a weekly basis is averaged and multiplied by four;

(b) income received on a biweekly basis is averaged and multiplied by two;

(c) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

F. Time limits for submission and processing an interim report form:

(1) An interim report form shall be mailed to a benefit group in the month prior to the month the report is due.

(2) A benefit group assigned to simplified reporting shall be required to submit an interim report form by the tenth calendar day of the month the interim report form is due in order to receive uninterrupted benefits.

(3) The interim report form shall be reviewed for completeness within ten days of receipt.

(a) If the form is complete and all verifications are provided, ISD shall complete the processing of the form within 10 days of receipt.

(b) If the form is complete and all

verifications are provided except for verification of an allowable deduction, the report shall be processed without the deduction. The household shall be:

(i) notified that verification is lacking; and

(ii) shall be given 10 days to provide verification of an allowable deduction;

(iii) a deduction that is verified within the month the interim report form is due shall be processed as part of the interim report;

(iv) a deduction that is verified in the month after the interim report form is due shall be processed as a change reported by the household;

(v) a deduction that does not have the required verification shall not be allowed until verification of the expense is provided.

(4) Incomplete interim report form is received**:**

(a) An interim report form that is not signed shall be returned to the household for a signature. The household:

(i) shall be notified that the form is incomplete;

(ii) what needs to be completed for the interim report form; and

(iii) shall be given 10 calendar days to provide the signed interim report form to be reviewed for completeness.

(b) An interim report form that is incomplete because required verification is not provided shall not be returned to the household. The household:

(i) shall be notified that the form is incomplete;

(ii) what information must be provided to complete the interim report form; and

(iii) shall be given 10 calendar days to provide the verification to process the interim report form.

(5) The benefit group must return the completed interim report form and all required verification within 10 calendar days to avoid a break in benefits. A benefit group that fails to submit an interim report form by the end of the month in which it is due, shall be issued a notice of case action.

G. Information requirements for the interim report form:
The interim report form shall specify:

(1) the date by which a benefit group must submit the form for uninterrupted benefits;

(2) the consequences of submitting a late or incomplete form;

(3) that verification must be submitted with the interim report form;

(4) where to call for help in completing the form;

(5) the consequences of providing incorrect information; and

(6) notice of rights.

H. Requirement to report certain changes between reporting periods: A benefit group must report changes within 10 days of the date a change becomes known to the benefit group:

(1) a benefit group reports income in excess of eighty-five percent of federal poverty guidelines for size of the benefit group;

(2) a parent must report when a dependent child, age six years or older, drops out of school or has three unexcused absences from school within 14 days of occurrence;

(3) a mandatory adult who is participating in NMW Program has moved in or out of the home;

(4) a mandatory child who has moved in or out of the home;

(5) a household member has passed away;

(6) a mandatory member has moved from New Mexico;

(7) unearned income in excess of the maximum monthly benefit for the size of the benefit group;

(8) changes in countable resources if the total of all countable resources for the benefit group exceed the $1,500 liquid or $2,000 non-liquid resource limit;

(9) 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.

I. Action on changes reported between reporting periods for benefit groups assigned to simplified reporting: In addition to changes that must be reported in accordance with Subsection H of 8.102.120.11 NMAC, ISD must act on changes in between interim report forms, if it would increase the household's benefits. ISD shall not act on changes that would result in a decrease in the household's benefits unless:

(1) The household has voluntarily requested that its case be closed;

(2) ISD has information about the household's circumstances considered verified upon receipt. Verified upon receipt is defined as:

(a) information is not questionable; and

(b) the provider of the information is the primary source of information;

(c) the trusted data sources must be pulling their own data not from third party information; or

(d) the recipient's attestation exactly matches the information received from a third party.

(3) A newborn shall be added to the benefit group effective the month following the month the report is received.

(4) The loss of earned income shall be considered for eligibility in the second month after the loss and ongoing until the next scheduled interim report or end of certification whichever is first,

provided that:

(a) the loss of income was reported to the agency, and verified by the benefit group; and

(b) the loss of income was not due to voluntary quit.

(5) The loss of unearned income shall be considered for eligibility in the month after the loss and ongoing until the next scheduled interim report or end of certification whichever is first, provided that the loss of income was reported to the agency, and verified by the benefit group.

(6) A household member has been identified as a fleeing felon or probation violator in accordance with 8.102.410.15 NMAC.

J. Responsibilities on reported changes outside of the interim report: When a household reports a change, ISD shall take action to determine the household's eligibility or TANF benefit amount within 10 working days of the date the change is reported.

(1) Decreased or termination of benefits: For changes that result in a decrease or termination of household benefits, ISD shall act on the change as follows:

(a) if the household's benefit level decreases or the household becomes ineligible as a result of the change, ISD shall issue a notice of adverse action within 10 calendar days of the date the change was reported unless one of the exemptions to the notice of adverse action in 7 CFR 273.13 (a)(3) or (b) applies.

(b) when a notice of adverse action is used, the decrease in the benefit level shall be made effective no later than the allotment for the month following the month in which the notice of adverse action period has expired, provided a fair hearing and continuation of benefits have not been requested.

(c) when a notice of adverse action is not used due to one of the exemptions in 7 CFR 273.13 (a)(3) or (b), the decrease shall be made effective no later than the month following the change. Verification which is required by 7 CFR 273.2(f) must be obtained prior to recertification.

(2) Increased benefits: For changes that result in an increase of household benefits, ISD shall act on the change as follows:

(a) for changes which result in an increase in a household's benefits, other than changes described in Subparagraph (b) of this section, ISD shall make the change effective no later than the first allotment issued 10 calendar days after the date the change was reported to ISD.

(b) for changes which result in an increase in a household's benefits due to the addition of a new household member who is not a member of another certified household, or due to a decrease of $50 or more in the household's gross monthly income, ISD shall make the change effective not later than the first allotment issued 10 calendar days after the date the change was reported.

(i) in no event shall these changes take effect any later than the month following the month in which the change is reported.

(ii) if the change is reported after the last day to make changes and it is too late for ISD to adjust the following month's allotment, ISD shall issue a supplement or otherwise provide an opportunity for the household to obtain the increase in benefits by the 10th calendar day of the following month, or the household's normal issuance cycle in that month, whichever is later.

(3) No change in TANF benefit amount: When a reported change has no effect on the TANF benefit amount, ISD shall document the change in the case file and notify the household of the receipt of the report.

(4) Providing verification: The household shall be allowed 10 calendar days from the date a change is reported to provide verification, if necessary. If verification is provided at the time a change is reported or by the deadline date, the increase in benefits shall be effective in accordance with Subparagraph (a) and (b) of Paragraph (2) above. If the household fails to provide the verification by the deadline date, but does provide it at a later date, the increase shall be effective in the month following the month the verification is provided. If the household fails to provide necessary verification, its SNAP benefit amount shall revert to the original benefit amount.

K. Resolving unclear information:

(1) During the certification period, ISD may obtain information about changes in a household's circumstances from which ISD cannot readily determine the effect of the change on the household's benefit amount. The information may be received from a third party or from the household itself. ISD must pursue clarification and verification of household circumstances using the following procedure if unclear information received outside the periodic report is:

(a) information fewer than 60 days old relative to the current month of participation; and,

(b) if accurate, would have been required to be reported under simplified reporting rules, in accordance with 8.102.120.11 NMAC.

(c) ISD must pursue clarification and verification of household circumstances in accordance with the process outlined in Subsection B of 8.100.130.12 NMAC, for any unclear information that appears to present significantly conflicting information from that used by ISD, at the time of certification.

(2) Unclear information resulting from certain data matches:

(a) if the HCA receives match information

from a trusted data source as described in 7 CFR 272.13 or 7 CFR 272.14, ISD shall send a notice in accordance with Subsection B of 8.100.130.12 NMAC in accordance with 7 CFR 272.13(b)(4) and 7 CFR 272.14 (c)(4). The notices must clearly explain what information is needed from the household and the consequences of failing to respond to the notice.

(b) if the household fails to respond to the notice or does respond but refuses to provide sufficient information to clarify its circumstances, ISD shall remove the individual and the individual's income from the household and adjust benefits accordingly. As appropriate, ISD shall issue a notice of adverse action.

L. Failure to report changes: If ISD discovers that the household failed to report a change as required, ISD shall evaluate the change to determine whether the household received benefits to which it was not entitled or if the household is entitled to an increased benefit amount.

(1) Decreased benefit amount: After verifying the change, ISD shall initiate a claim against the household for any month in which the household was over issued TANF benefits. The first month of the over issuance is the month following the month the adverse action notice time limit would have expired had the household timely reported the change. If the discovery is made within the certification period, the household is entitled to a notice of adverse action if its benefits will be reduced.

(2) Increased benefit amount: When a household fails to timely report a change which will result in an increased TANF benefit amount, the household is not entitled to a supplement for any month prior to and including the month in which the change was reported. The household is entitled to an increased benefit amount effective no later than the first benefit amount issued 10 calendar days after the date the change was reported.

M. Non-reporting sanctions: A benefit group assigned to simplified reporting shall be subject to a non-reporting sanction in accordance with regulations at 8.102.620.11 NMAC for failure to provide accurate change information on the interim report form or for failure to report by the tenth calendar day of the month following the month that household income exceeds eighty-five percent of federal poverty guidelines for the size of the benefit group.
[8.102.120.11 NMAC - Rp 8.102.120.11 NMAC, 7/1/2024]

History of 8.102.120 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 272.000, Procedures and Conditions Applicable to Continuing Eligibility for Financial and Medical Assistance, 5/22/80.
ISD FA 520, Eligibility Reviews, 2/11/1988.
ISD FA 510, Monthly Reporting and Changes, 2/10/1988.
ISD FA 510, Changes in Budget Group Circumstances, 4/30/1992.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 7/1/1997.
8.102.120 NMAC Eligibility Policy - Administration - Repealed, 7/1/2001.
8.102.120 NMAC - Eligibility Policy - Case Administration (filed 6/18/2001) Repealed effective, 7/1/2024.

Other: 8.102.120 NMAC - Eligibility Policy - Case Administration (filed 6/18/2001) Replaced by 8.102.120 NMAC - Eligibility Policy - Case Administration effective, 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 230 GENERAL FINANCIAL - PAYABLES AND DISBURSEMENT

8.102.230.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.230.1 NMAC - Rp 8.102.230.1 NMAC, 7/1/2024]

8.102.230.2 SCOPE: The rule applies to the general public.
[8.102.230.2 NMAC - Rp 8.102.230.2 NMAC, 7/1/2024]

8.102.230.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its financial assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security

Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. 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.
[8.102.230.3 NMAC - Rp 8.102.230.3 NMAC, 7/1/2024]

8.102.230.4 DURATION: Permanent.
[8.102.230.4 NMAC - Rp 8.102.230.4 NMAC, 7/1/2024]

8.102.230.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.230.5 NMAC - Rp 8.102.230.5 NMAC, 7/1/2024]

8.102.230.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

B. 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 like NMW or the federal program of supplemental security income (SSI).

C. 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.

D. The objective of the burial assistance program is to assist in payment of burial expenses for deceased, low-income individuals.
[8.102.230.6 NMAC - Rp 8.102.230.6 NMAC, 7/1/2024]

8.102.230.7 DEFINITIONS: [**RESERVED**]
[8.102.230.7 NMAC - Rp 8.102.230.7 NMAC, 7/1/2024]

8.102.230.8 [**RESERVED**]
[8.102.230.8 NMAC - Rp 8.102.230.8 NMAC, 7/1/2024]

8.102.230.9 DEATH OF CLIENT:

A. Payment: Payment may be made on behalf of a client who died before an EBT withdrawal was made, if the client was alive on the first day of the month for which cash assistance benefits were issued, and all eligibility conditions were met at the time of death. The person authorized to use the deceased recipient's benefits is the surviving spouse, next of kin, or a person with responsibility for the deceased recipient's affairs.

B. Withdrawing EBT benefits: When payment is made in accordance with these procedures, the county office shall not restrict or dictate the use of the money paid.
[8.102.230.9 NMAC - Rp 8.102.120.10 NMAC, 7/1/2024]

History of 8.102.230 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 271.0000, Procedures Applicable to Payment and Related Changes, 5/16/1980.
ISD FA 450, Payment, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.230 NMAC General Financial - Payables and Disbursement - Repealed, 07/01/2001.
8.102.230 NMAC General Financial - Payables and Disbursement, (filed 6/18/2001) – Repealed, effective 7/1/2024.

Other: 8.102.230 NMAC General Financial - Payables and Disbursement, (filed 6/18/2001) - Replaced by 8.102.230 NMAC General Financial - Payables and Disbursement, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 400 RECIPIENT POLICIES - DEFINING THE ASSISTANCE GROUP

8.102.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.400.1 NMAC - Rp 8.102.400.1 NMAC, 7/1/2024]

8.102.400.2 SCOPE: The rule applies to the general public.
[8.102.400.2 NMAC - Rp 8.102.400.2 NMAC, 7/1/2024]

8.102.400.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April

1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.400.3 NMAC - Rp 8.102.400.3 NMAC, 7/1/2024]

8.102.400.4 DURATION: Permanent.
[8.102.400.4 NMAC - Rp 8.102.400.4 NMAC, 7/1/2024]

8.102.400.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.400.5 NMAC - Rp 8.102.400.5 NMAC, 7/1/2024]

8.102.400.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term carrier development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.
[8.102.400.6 NMAC - Rp 8.102.400.6 NMAC, 7/1/2024]

8.102.400.7 DEFINITIONS: [**RESERVED**]
[8.102.400.7 NMAC - Rp 8.102.400.7 NMAC, 7/1/2024]

8.102.400.8 WHO CAN BE A RECIPIENT: To be a recipient of cash assistance, a person must be individually eligible according to requirements set forth in 8.102.410 NMAC and 8.102.420 NMAC. The person or persons meeting individual eligibility requirements and for whom application has been or must be made constitute the benefit group.
[8.102.400.8 NMAC - Rp 8.102.400.8 NMAC, 7/1/2024]

8.102.400.9 BASIS FOR DEFINING THE BENEFIT GROUP:

A. At time of application for cash assistance and services, an applicant and the HCA shall identify everyone who is to be considered for inclusion in the benefit group. A decision to request assistance for a specific individual may require the inclusion of other individuals as well. There may be more than one benefit group in a residence.

B. ISD shall add or delete a person from the benefit group upon request of the household, except when the participant is a mandatory benefit group member. Changes in benefit group composition must be evaluated as it may affect who must be included in the benefit group.

C. Benefit groups containing dependent children: The benefit group for the NMW cash assistance program or EWP cash assistance program consists of a pregnant woman or a group of people that includes a dependent child, all of that dependent child's full, half, step- or adopted siblings living with dependent child's parent or relative within the fifth degree of relationship and the parent with whom the children live and the spouse of a parent.

D. NMW Adult only benefit groups: An adult only benefit group may consist of:

(1) a parent or relative, and the spouse of the parent or relative, when all of the dependent children are receiving SSI;

(2) a pregnant woman in her third trimester of pregnancy who has no dependent children living with her and the father of the unborn child, if he is living in the home.
[8.102.400.9 NMAC - Rp 8.102.400.9 NMAC, 7/1/2024]

8.102.400.10 MANDATORY MEMBERS: Certain participants must be included in the dependent child assistance group, provided they meet the eligibility requirements.

A. Include the dependent child who is the natural child, adopted child, or stepchild who is 17 years of age or younger or who are 18 years of age and enrolled in high school.

B. Include all of that dependent child's full, half, step-siblings or adopted siblings living with the dependent child.

C. Include the natural parent, adoptive parent, or stepparent of the dependent child for whom assistance is being requested.

D. Include in the benefit group the parent of any child included in the budget group and the spouse of the parent, if living in the home.
[8.102.400.10 NMAC - Rp 8.102.400.10 NMAC, 7/1/2024]

8.102.400.11 OPTIONAL MEMBERS: NMW dependent child benefit groups may include in the benefit group:

A. any unrelated dependent child living in the home;

B. the specified relative who is a caretaker and who is within the fifth degree of relationship and the specified relative's spouse, if the parent is not living in the home;

C. any dependent child who is within the fifth degree of relationship and not full, half, step or adopted sibling of the dependent child whom the assistance is requested;

D. the legal guardian(s) of the dependent child.
[8.102.400.11 NMAC - Rp 8.102.400.11 NMAC, 7/1/2024]

8.102.400.12 SPECIAL MEMBERS

A. Minor unmarried parents:

(1) A minor unmarried parent and child who live with the minor unmarried parent's parent or other adults shall be included as dependent children in the larger NMW benefit group if there is one. A minor unmarried parent and child living with parent(s) may constitute a benefit group in their own right if the minor parent is the primary caretaker for the child and the parent(s) are not receiving NMW. The minor parent's parent shall be the applicant and payee for the benefit.

(2) Limitations regarding minor unmarried parents:

(a) Living arrangements: An unmarried minor parent and the dependent child in her care must reside in the household of a parent, legal guardian, or other adult relative unless:

(i) the child is living in a second-chance home, maternity home, or other appropriate adult-supervised supportive living arrangement which takes into account the needs and concerns of the minor unmarried parent;

(ii) the minor parent has no living parent or legal guardian whose whereabouts is known, and there are no other appropriate adult-supervised supportive living arrangements available;

(iii) no living parent or legal guardian of the minor parent allows the minor parent to live in the minor parent's home and there are no other appropriate adult-supervised supportive living arrangements available;

(iv) the minor unmarried parent is or has been subjected to serious physical or emotional harm, sexual abuse, or exploitation in the home of the parent, legal guardian or other adult relative and there are no other appropriate adult-supervised supportive living arrangements available;

(v) there is substantial evidence of an act or failure to act that presents an imminent or serious harm to the minor unmarried parent or the child of the minor unmarried parent if they live in the same residence with the parent legal guardian or other appropriate adult and there are no other appropriate adult-supervised supportive living arrangements available; if a minor parent makes allegations supporting the conclusion that the physical or emotional health or safety of the minor unmarried parent or the dependent child(ren) will be jeopardized, the caseworker shall file any documentation regarding this allegation in the case record and grant the exemption; acceptable documentation will include written reports and statements from the children, youth, and families department, other social service agencies, and police reports; if no written documentation exists, the caseworker should summarize the client's statement in a memo to the ISD director or designee and a determination shall be made.

(vi) the HCA determines there is otherwise good cause for the minor parent and dependent child to receive assistance while living apart from the minor parent's parent, legal guardian, or other adult relative, or an adult-supervised supportive living arrangement; an adult-supervised supportive living arrangement is defined as a private family setting or other living arrangement (not including a public institution), which is maintained as a family setting, as evidenced by the assumption of responsibility for the care and control of the minor parent and dependent child or the provision of supportive services, such as counseling, guidance, or supervision; for example, foster homes and maternity home are adult-supervised supportive living arrangements.

(b) Notification: Minor applicants shall be informed about the eligibility requirements and their rights and obligations under this manual section. Minor applicants shall be advised of the possible exemptions and specifically asked whether one or more of these exemptions applies in their situation.

(c) Payment: If the minor parent lives with an adult receiving NMW, the minor parent and child shall be included in that NMW benefit group. If the minor parent and the minor parent's dependent child do not live with an adult who is receiving NMW, payment is made to the supervising adult in the form of a protective payment.

B. Pregnant woman:

(1) A pregnant woman who has no minor dependent children living with her can constitute a NMW benefit group during her last trimester of pregnancy. The woman is eligible only if the child, were it born, would be living with her and would be eligible for NMW. The pregnancy must be verified by a medical report.

(2) The needs, income and resources of an unborn child shall be considered in the determination of eligibility for NMW. The needs of the unborn child are not considered in the amount of payment.

(3) Father living with the pregnant woman: The needs, income and resources of the father of the unborn child shall be considered in determining eligibility and payment if the father lives in the home. The mother and the alleged father of the unborn child must provide the HCA with a written sworn statement attesting to paternity.

(4) A pregnant woman who has one or more dependent children living with her must meet the conditions of Subsection H of 8.102.400.9 NMAC; benefit groups containing dependent children.

C. Specified relative of SSI child: A specified relative whose only minor dependent child is an SSI recipient meets the requirement of

living with a related minor child and constitutes a NMW benefit group. Other household members may also be included, subject to limitations set forth at 8.102.400.10 NMAC and 8.102.400.11 NMAC.
[8.102.400.12 NMAC - Rp 8.102.400.12 NMAC, 7/1/2024]

8.102.400.13 [RESERVED]
[8.102.400.13 NMAC - Rp 8.102.400.13 NMAC, 7/1/2024]

8.102.400.14 NMW LIVING ARRANGEMENTS - REQUIREMENTS:

A. For a NMW benefit group to exist, a dependent child must be living in the home of a parent or specified relative as specified in 8.102.400.15 NMAC. The relative must be the primary caretaker for the child and must be within the fifth degree of relationship, as determined by New Mexico's Uniform Probate Practice Code (see Subsection A of 8.102.400.16 NMAC). To be considered as the caretaker, the specified relative in a NMW benefit group, the participant must be living, or considered to be living, in the home with the child.

B. A child or the caretaker relative may in certain situations be temporarily domiciled away from home, but nonetheless be considered as living at home. Such situations result when the parent or caretaker relative has decided to domicile the child elsewhere because of a specific need identified by the parent or caretaker relative and provided that the parent or caretaker relative remains responsible for providing care and support to the child and retains parental control over the child.
[8.102.400.14 NMAC - Rp 8.102.400.14 NMAC, 7/1/2024]

8.102.400.15 NMW LIVING IN THE HOME

A. Basic requirements:

(1) To be eligible for inclusion in the NMW cash assistance benefit group, the dependent child must live with a parent or a specified relative acting as the head of household. A child lives with a participant when:

(a) the participant's home is the primary place of residence for the child, as evidenced by the child's customary physical presence in the home;

(b) the participant may or may not be the child's parent or caretaker;

(c) the caretaker is the person taking primary responsibility for the care of the child, the caretaker will be a parent, relative or it may be an unrelated adult; the caretaker may or may not be the head of household.

(2) The determination of whether a given participant functions as the parent or caretaker relative for NMW purposes shall be made by the client unless other information known to the caseworker clearly indicates otherwise.

B. Extended living in the home:

(1) Under the circumstances described in this section, a child may be physically absent from the home for periods of time, but, because of the nature of the absence and because the parent or caretaker relative continues to exercise parental control over and to provide care for the child during the time the child is physically away from the family's home, the child nonetheless remains a regular on-going member of the benefit group. Similarly, under certain circumstances, the caretaker could be physically absent from the home and still retain membership status as caretaker for purposes of eligibility.

(2) The circumstances where this occurs are:

(a) attending boarding schools or college and

(b) inpatient treatment in medicaid facilities; in order for either the child or the caretaker to retain living-in-the-home status, the person acting as the caretaker must retain responsibilities for providing care, support and supervision for the child which are appropriate to the child's specific living arrangements.

(3) In considering whether the caretaker retains care and support responsibilities for a child who is hospitalized or at school, issues which shall be reviewed include the degree to which the parent:

(a) provides financial support to the child from the cash assistance payment;

(b) continues to maintain living quarters for the child until the child reestablishes full-time physical presence in the home; and

(c) continues to make decisions regarding the care and control of the child(ren), including decisions about medical care and treatment, class scheduling, and other similar parental decisions;

(d) maintains contact with the child through regular visits or telephone calls.

(4) The determination whether living-in-the-home status is retained is fully discussed with the caretaker and carefully documented in the case record.

(a) Boarding school: A child or caretaker relative who is attending school away from home lives in the home if the caretaker relative retains primary responsibility for the child relative.

(b) Medicaid:

(i) Caretaker: A caretaker receiving treatment in a Title XIX facility remains a member of the benefit group of which the caretaker was a member at the time of hospitalization until the caretaker leaves the facility and returns to that home or some other. If the caretaker does not return to the home following hospitalization, the living-in-the-home requirement shall be reassessed.

(ii) Dependent children: For the purposes of the cash assistance program, a child hospitalized for care or treatment in a Title XIX (medicaid)

facility retains living-in-the-home status, without regard to the length of hospitalization, provided that the caretaker continues to be the person with primary responsibility for control of the child and for meeting the child's physical and emotional needs. This includes children receiving treatment in acute care hospitals, freestanding psychiatric hospitals and rehabilitation hospitals as well as residential treatment centers and group homes reimbursed by medicaid for psychosocial rehabilitation services. Medical assistance division institutional care staff may be contacted to verify New Mexico medicaid provider status of RTCs and group homes.

(5) For a child to retain living-in-the-home status while receiving rehabilitation services, including psychosocial treatment services, certain conditions must be met. Treatment of the child is the primary objective, but the program should be family-based with one objective being strengthening of family ties. Treatment plans must provide for a significant level of continuing authority, responsibility, and participation by the caretaker. In order for children receiving treatment in a Title XIX facility to be "living in the home", the caretaker must retain the authority to decide when the child should leave the facility, grant authority for provision of necessary treatment, and retain responsibility for provision of pocket money, clothing, etc.

(6) A significant issue in determining whether a child retains living-in-the-home status is the authority of the caretaker to control the child's treatment and duration of stay. Under the state's mental health code, a court order placing the child in a psychiatric facility must be issued. The court findings serve to make sure that the child needs such treatment. Such orders do not prevent the specified relative from removing the child from the facility. These orders must be differentiated from correctional commitments or sentences. A child receiving treatment in a Title XIX facility, or placed in other substitute care living arrangements by juvenile authorities as the result of a sentence or commitment by a judicial authority does not meet the definition of actually living in the home, as the caretaker no longer has significant control over the child.

(7) A child may qualify for extended living-in-the-home provisions under these conditions:

(a) the child must have been living in the home before hospitalization;

(b) the child must have been living in the home before attending boarding school or college.

C. Joint custody: A child who is in the joint custody of divorced parents who are living apart and who is actually spending equal amounts of time with both parents shall not be considered to be living with the caretaker. If the divorce decree specifies equal joint custody, but the child is actually spending more time with one parent than the other, the child would be determined to be living with the parent with whom the child spends the most time.

D. Absence from the home:

(1) A minor child may remain in the benefit group and remain eligible for benefits for up to 45 days following the date of departure or expected absence from the home. Such a child may not simultaneously be in another NMW or GA benefit group.

(2) A child shall be considered to have left the home, when the child is physically absent from the home and is under the care, control, custody, of himself, another relative or another adult, social services or correctional agency, or other agency of state, local, or tribal government.

E. Reporting departure of child from the home: Pursuant to Section 408 (a)(10)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the parent, relative, or caretaker of a minor child included in the NMW benefit group is ineligible to be included in the benefit group if the parent or relative or caretaker fails to report the absence from the home of a minor child who is a member of the benefit group. To be eligible, the adult must report the departure of the minor child by no later than five days after the adult becomes aware that the child is absent or will be absent in excess of the 45 days allowed under Subsection D of 8.102.400.15 NMAC. The adult shall remain ineligible for the number of months that the benefit group is sanctioned for non-reporting as provided for at 8.102.620.11 NMAC.
[8.102.400.15 NMAC - Rp 8.102.400.15 NMAC, 7/1/2024]

8.102.400.16 RELATIONSHIP

A. NMW requirement:

(1) The following relatives are within the fifth degree of relationship to the dependent child:

(a) father (biological or adoptive);

(b) mother (biological or adoptive);

(c) grandfather, great grandfather, great-great grandfather, great-great-great grandfather;

(d) grandmother, great-grandmother, great-great-grandmother, great-great-great grandmother;

(e) spouse of child's parent (stepparent);

(f) spouse of child's grandparent, great grandparent, great-great grandparent, great-great-great grandparent (step-grandparent);

(g) brother, half-brother, brother-in-law, stepbrother;

(h) sister, half-sister, sister-in-law, stepsister;

(i) uncle of the whole or half-blood, uncle-in-law, great uncle, great-great uncle;

(j) aunt of the whole or half blood, aunt-in-law, great aunt, great-great aunt;

(k)

first cousin and spouse of first cousin;

(l) son or daughter of first cousin (first cousin once removed);

(m) son or daughter of great aunt or great uncle (first cousin once removed) and spouse;

(n) nephew/niece and spouses.

(2) A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

(3) GA is not provided to dependent children where a NMW application has been made and verification of relationship is pending.

(4) Below is the table of relationship based on the Uniform Probate Practice Code. The relationships shown with an "X" are not within the fifth degree of relationship.

B. Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law", or "step-" relationships, continues to exist following the dissolution of the marriage by divorce or death.

C. Table of relationships:

					5 Great-Great-Great Grandparents
				4 Great-Great Grandparents	X
			3 Great Grandparents	5 Great-Grand Uncles and Aunts	
		2 Grandparents	4 Great Aunt Great Uncle	X	
	1 Parents	3 Aunt/Uncle	5 First Cousin Once-Removed		
Dependent Child	2 Siblings	4 First Cousins	X		
	3 Nephew/ Niece	5 First Cousin Once-Removed			
	4 Grand Nephew Grand Niece	X			
	5 Great Grand Nephew or Niece				
	X				

D. Verifying relationship: Standards for verification of relationship are set forth at Subsection H of 8.100.130.13 NMAC.

[8.102.400.16 NMAC - Rp 8.102.400.16 NMAC, 7/1/2024]

History of 8.102.400 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD FA 220, AFDC/GA Budget Group, 2/9/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.400 NMAC Recipient Policies- Defining the Assistance Group - Repealed 07/01/2001.

8.102.400 NMAC - Recipient Policies - Defining The Assistance Group (filed 6/18/2001) Repealed, effective 7/1/2024.

Other: 8.102.400 NMAC - Recipient Policies - Defining The Assistance Group (filed 6/18/2001) Replaced by 8.102.400 NMAC - Recipient Policies - Defining The Assistance Group, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 410 RECIPIENT POLICIES - GENERAL RECIPIENT REQUIREMENTS

8.102.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.410.1 NMAC - Rp 8.102.410.1 NMAC, 7/1/2024]

8.102.410.2 SCOPE: The rule applies to the general public.
[8.102.410.2 NMAC - Rp 8.102.410.2 NMAC, 7/1/2024]

8.102.410.3 STATUTORY AUTHORITY:
A. 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.
B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.
C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.
D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.
E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.
F. 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.
[8.102.410.3 NMAC - Rp 8.102.410.3 NMAC, 7/1/2024]

8.102.410.4 DURATION: Permanent.
[8.102.410.4 NMAC - Rp 8.102.410.4 NMAC, 7/1/2024]

8.102.410.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.410.5 NMAC - Rp 8.102.410.5 NMAC, 7/1/2024]

8.102.410.6 OBJECTIVE:
A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.
B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.410.6 NMAC - Rp 8.102.410.6 NMAC, 7/1/2024]

8.102.410.7 DEFINITIONS: [**RESERVED**]
[8.102.410.7 NMAC - Rp 8.102.410.7 NMAC, 7/1/2024]

8.102.410.8 REQUIREMENTS: This section describes eligibility requirements which each recipient of cash assistance must meet in order to be included in the benefit group.
[8.102.410.8 NMAC - Rp 8.102.410.8 NMAC, 7/1/2024]

8.102.410.9 ENUMERATION: The participant, or the specified relative on behalf of a dependent child, must report the participant's social security number (SSN) within 60 days of approval for the cash assistance program. Failure to meet this requirement shall result in ineligibility for the benefit group member without a reported or verified SSN.
[8.102.410.9 NMAC - Rp 8.102.410.9 NMAC, 7/1/2024]

8.102.410.10 CITIZENSHIP AND NON-CITIZEN STATUS:
A. Eligibility for TANF funded cash assistance:
(1) Participation in the NMW cash assistance program is limited to a U.S. citizen, a naturalized citizen or a non-citizen U.S. national.
(2) A non-citizen, other than a non-citizen U.S. national, must be both a qualified and eligible non-citizen in order to participate in the NMW cash assistance program.
B. Definitions:
(1) Continuously lived in the U.S.: means that a non-citizen has lived in the U.S. without a single absence of more than 30 days or has lived in the U.S. without a total of aggregated

absences of more than 90 days.

(2) Federal means-tested public benefit: means benefits from the food stamp program; the food assistance block grant programs in Puerto Rico, American Samoa, and the commonwealth of the Northern Mariana Islands; supplemental security income (SSI); and the TANF block grant program under title IV of the Social Security Act; medicaid, and SCHIP.

(3) Five-year bar: means the federally imposed prohibition on receiving federal means-tested public benefits for certain qualified non-citizens who entered the United States on or after August 22, 1996, until they have continuously lived in the U.S for five years. If an non-citizen enters the U.S. on or after August 22, 1996, but does not meet the definition of a qualified non-citizen, the five-year bar begins on the date the non-citizen attains qualified non-citizen status.

(4) Immigrant: means a non-citizen within the meaning found in title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(5) Non-citizen U.S. national: means a person who is not a U.S. citizen but was born in an outlying possession of the United States on or after the date the U.S. acquired the possession, or a person whose parents are non-citizen U.S. nationals. A person who resides on one of the following U.S. island territories is a non-citizen U.S. national: American Samoa, Swains Island or the Northern Mariana Islands.

(6) Permanently residing under color of law (PRUCOL): means a person whose presence in the US is known by the department of homeland security (DHS) and the DHS does not intend to deport the person. Persons classified as PRUCOL may or may not also be qualified non-citizens.

C. **Qualified non-citizen:** A qualified non-citizen is any of the following types of non-citizens:

(1) who is lawfully admitted for permanent residence under the Immigration and Nationality Act (an LPR);

(2) who is granted asylum under Section 208 of the INA (an asylee);

(3) who is a refugee admitted to the U.S. under Section 207 of the INA (a refugee);

(4) who is paroled into the U.S. under Section 212(d)(5) of the INA for at least one year (a parolee);

(5) whose deportation is being withheld under Section 241(b)(3) or 243(h) of the INA;

(6) who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(7) who is a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

(8) who is a victim of a severe form of trafficking, regardless of immigration status, under the Trafficking Victims Protection Act of 2000.

D. Qualified non-citizen due to battery or extreme cruelty: means a non-citizen regardless of status who has been battered or subjected to extreme cruelty, as long as the following elements are met:

(1) there is a substantial connection between such battery or cruelty and the need for the cash benefits; and

(2) the abused non-citizen is not currently living with the abuser; and

(3) the INS or executive office of immigration review (EOIR) has:

(a) approved a self-petition seeking permanent residency, or

(b) approved a petition for a family based immigrant visa; or

(c) approved an application for cancellation of removal or suspension of deportation; or

(d) found that a pending petition or application establishes "prima facie" (true and valid) case for approval; and

(4) the non-citizen has been battered or subjected to extreme cruelty in the US by a spouse or parent, or by a member of the spouse or parent's family residing in the same household as the abused non-citizen and the spouse or parent of the abused non-citizen consented to, or acquiesced in such battery or cruelty; or

(5) the non-citizen has a child who has been battered or subjected to extreme cruelty in the US by the non-citizen's spouse or parent, as long as the non-citizen does not actively participate in the battery or cruelty; or a non-citizen whose child is battered or subjected to extreme cruelty by a member of the non-citizen's spouse or parent's family residing in the same household and the non-citizen's spouse or parent consented or acquiesced to such battery or cruelty; or

(6) the non-citizen is a child who resides in the same household as a parent who has been battered or subjected to extreme cruelty in the US by the parent's spouse or by a member of the spouse's family residing the same household and the non-citizen's spouse consented or acquiesced to such battery or cruelty.

(7) U.S. citizen: means, but may not be limited to:

(a) a person born in the United States;

(b) a person born in Puerto Rico, Guam, U.S. Virgin Islands or Northern Mariana Islands who has not renounced or otherwise lost their citizenship;

(c) a person born outside the U.S. to at least one U.S. citizen parent; or

(d) a person who is a naturalized citizen.

E. Non-citizens who are eligible to participate: A non-citizen who meets the definition of a qualified non-citizen shall be eligible

to participate in the NMW cash assistance program if the non-citizen:

(1) physically entered the U.S. prior to August 22, 1996, and obtained qualified non-citizen status before August 22, 1996;

(2) physically entered the U.S. prior to August 22, 1996, obtained qualified non-citizen status on or after August 22, 1996, and has continuously lived in the U.S. from the latest date of entry prior to August 22, 1996 until the date the participant or applicant obtained qualified non-citizen status;

(3) physically entered the U.S. on or after August 22, 1996, meets the definition of a qualified non-citizen and has been in qualified non-citizen status for at least five years (five year bar);

(4) physically entered the U.S. before August 22, 1996, and did not continuously live in the U.S. from the latest date of entry prior to August 22, 1996, until obtaining qualified non-citizen status, but has been in qualified non-citizen status for at least five years;

(5) is a lawfully admitted permanent resident non-citizen under the INA, who has worked or can be credited with 40 qualifying quarters; or

(6) is a veteran of the military with an honorable discharge that is not based on non-citizen status who has fulfilled the minimum active duty requirements; or the non-citizen who is on active duty military service; or the person is the spouse, surviving spouse who has not remarried, or an unmarried dependent child of a veteran or active duty service member;

(7) an non-citizen is eligible for a period of five years from the date a non-citizen:

(a) is granted status as an asylee under Section 208 of the INA;

(b) is admitted as a refugee to the U.S. under Section 207 of the INA;

(c) has had their deportation withheld under Section 241(b)(3) or 243(h) of the INA;

(d) is admitted as an Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988; or

(e) is admitted as a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980; and

(8) a qualified non-citizen who entered the United States on or after August 22, 1996, to whom the five-year bar applies, may participate in the state-funded TANF program without regard to how long the non-citizen has been residing in the United States.

F. Victim of severe form of trafficking: A victim of a severe form of trafficking, regardless of immigration status, who has been certified by the U.S. department of health and human services (DHHS), office of refugee resettlement (ORR), is eligible to the same extent as a refugee.

(1) The date of entry for a victim of trafficking is the date of certification by ORR (which appears in the body of the eligibility letter from the ORR).

(2) A victim of a severe form of trafficking:

(a) must have and present a certification of eligibility letter from ORR for adults or letter for children (similar to but not necessarily a certification letter) as proof of status; and

(b) is not required to provide any immigration documents, but may have such documents and may present such documents.

(3) Determining eligibility for a victim of trafficking must include a call to the trafficking verification line at 1-866-401-5510.

(4) The caseworker must inform ORR of the benefits for which the victim of trafficking has applied.

G. Quarters of coverage:

(1) SSA reports quarters of coverage through the quarters of coverage history system (QCHS).

(2) The number of qualifying quarters is determined under Title II of the Social Security Act, including qualifying quarters of work not covered by Title II of the Social Security Act, and is based on the sum of: quarters the non-citizen worked; quarters credited from the work of a parent of the non-citizen before the non-citizen became 18 (including quarters worked before the non-citizen was born or adopted); and quarters credited from the work of a spouse of the non-citizen during their marriage if they are still married or the spouse is deceased.

(a) A spouse may not get credit for quarters of a spouse when the couple divorces prior to a determination of eligibility.

(b) If eligibility of a non-citizen is based on the quarters of coverage of the spouse, and then the couple divorces, the non-citizen's eligibility continues until the next recertification. At that time, the caseworker shall determine the non-citizen's eligibility without crediting the non-citizen with the former spouse's quarters of coverage.

(3) Disputing quarters: If a participant or applicant disputes the SSA determination of quarters of coverage, the participant may not participate based on having 40 qualifying quarters until a determination is made that the participant or applicant can be credited with 40 qualifying quarters. The participant or applicant may participate as a state-funded benefit group member, if otherwise eligible.

(4) Federal means-tested benefit: After December 31, 1996, a quarter in which a non-citizen received any federal means-tested public benefit, as defined by the agency providing the benefit shall not be credited toward the 40-quarter total. A parent's or spouse's quarter is not creditable if the parent or spouse actually received any federal means-tested public benefit. If the non-citizen earns the 40th quarter of coverage prior to applying for a

federal means- tested public benefit in that same quarter, the caseworker shall allow that quarter toward the 40 qualifying quarters total.

H. Verification of citizenship/eligible non-citizen status: U.S. citizenship is verified only when client statement of citizenship is inconsistent with statements made by the applicant or with other information on the application, previous applications, or other documented information known to HSD.

(1) Questionable U.S. citizenship: Any mandatory benefit group member whose U.S. citizenship is questionable is ineligible to participate until proof of U.S. citizenship is obtained. The member whose citizenship is questionable shall have all of their resources and a pro rata share of income considered available to any remaining benefit group members.

(2) Eligible non-citizen status: Verification of eligible non-citizen status is mandatory at initial certification. Only those benefit group members identified as non-citizens with qualified and eligible non-citizen status are eligible to participate in the NMW program.

(3) Ineligible or questionable non-citizen status: Any household member identified as an ineligible non-citizen, or whose non-citizen status is questionable cannot participate in the NMW program.

I. Need for documentation:

(1) Benefit group members identified as non-citizens must present documentation, such as but not limited to, a letter, notice of eligibility, or identification card which clearly establishes that the non-citizen has been granted legal status.

(2) A caseworker shall allow a non-citizen a reasonable time to submit acceptable documentation of eligible non-citizen status. A reasonable time shall be 10 days after the date the caseworker requests an acceptable document, or until the 30th day after application, whichever is longer.

(3) If verification of a participant 's eligible status is not provided by the deadline, the eligibility of the remaining benefit group members shall be determined. Verification of eligible non-citizen status provided at a later date shall be treated as a reported change in benefit group membership.

(4) During the application process, if an individual has been determined to be a qualified non-citizen and either the individual or HSD submits a request to a federal agency for documentation to verify eligible non-citizen status, HSD must certify the individual in the TANF benefit group as a state-funded participant until a determination is made that the individual is eligible for TANF funded cash assistance.

(5) Inability to obtain INS documentation: If a benefit group indicates an inability to provide documentation of non-citizen status for any mandatory member of the benefit group, that member shall be considered an ineligible non-citizen. The caseworker shall not continue efforts to contact INS when the non-citizen does not provide any documentation from INS.

J. Failure to cooperate: If a benefit group or a benefit group member indicates an unwillingness to provide documentation of non-citizen status for any member, that member shall be considered an ineligible non-citizen. The caseworker shall not continue efforts to get documentation.

K. Reporting undocumented (illegal) non-citizens:

(1) HSD shall inform the local DHS office only when an official determination is made that any mandatory member of a benefit group who is applying for and receiving benefits is present in the U.S. in violation of the INA. A determination that a non-citizen is in the US in violation of the INA is made when:

(a) the non-citizens unlawful presence is a finding of fact or conclusion of law that is made by HSD as part of a formal determination about the individuals eligibility; and

(b) HSD's finding is supported by a determination by DHS or the executive office of immigration review (EOIR) that the non-citizen is unlawfully residing in the U.S. such as a final order of deportation.

(2) An non-citizen who resides in the US in violation of the INA shall be considered an ineligible benefit group member until there is a finding or conclusion of law through a formal determination process by the INS or EOIR.

(3) Illegal non-citizen status is considered reported when the caseworker enters relevant information about the non-citizen on the benefit group's computer file.

(4) A systematic alien verification for entitlements (SAVE) response showing no service record on an individual or an immigration status making the individual ineligible for a benefit is not a finding of fact or conclusion of law that the individual is not lawfully present.

L. Income and resources of ineligible non-citizens: All the resources and a prorated share of income of an ineligible non-citizen, or of a non-citizen whose status is unverified, shall be considered in determining eligibility and the cash assistance benefit amount for the remaining eligible benefit group members.

[8.102.410.10 NMAC - Rp 8.102.410.10 NMAC, 7/1/2024]

8.102.410.11 RESIDENCE:

A. To be eligible for inclusion in a benefit group, the individual must be living in New Mexico (NM) and demonstrate an intention to stay. At application, the residency determination shall be made prior to the date cash assistance is authorized. Once established, NM residency continues until the individual takes action to end it.

B. Residence shall not be considered to exist if the person is just passing through or is present in

NM for purposes such as vacation, family visits, medical care, temporary employment, or other similar short-term stays where the person does not intend to remain. Residence shall not exist if an individual claims residence in another state.

C. Establishing residence: Residence in New Mexico shall be established by being present in the state on an ongoing basis and carrying out the types of activities associated with normal day-to-day living, such as occupying a house, enrolling a child in school, renting a post office box, obtaining a state driver's license, joining a church or other local organization, obtaining or seeking a job in the state, registering to vote in the state, etc.

D. Homeless persons: A homeless person must meet the residence requirement; however, their personal situations may prevent them from establishing the types of residence indicators listed above. As much information as possible shall be obtained and entered into the record, but absence of the more common types of verifications shall not be a barrier to eligibility.

E. Assistance from another state: An individual receiving assistance from another state shall be considered a resident of that state, until that state is notified of the individual's intention to abandon residence. An individual who received TANF from another state shall be considered to be in receipt of concurrent assistance for that month, as set forth in 8.102.410.12 NMAC.

F. Temporary absence from the state:

(1) A temporary absence from the state shall not be considered an interruption of residence. Temporary absence occurs when an individual leaves the state for a specific, time-limited purpose. After the temporary absence, the individual must intend to return to the state. An absence related to the following purposes shall be considered temporary:

(a) short-term visits with family or friends for 30 days or less;

(b) out-of-state stays for medical treatment;

(c) attendance at an out-of-state school, with returns to the state during vacations.

(2) A statement by a participant of intent to return to the state will be accepted, provided that the participant does not take action in another state to establish permanent residence.

G. Residency abandonment: Residence shall be considered to have been abandoned when:

(1) an individual leaves the state and indicates that an intent to establish residence in the other state; or

(2) an individual leaves the state for no specific purpose and with no clear intention to return;

(3) an individual leaves the state and applies for food, financial or medical assistance from another state, which makes residence in that state a condition of eligibility; or

(4) an individual has been absent from the state for a period of more than 30 days and has not notified the caseworker of the absence or of any intention to return.

H. Residence of children: A dependent child shall be considered to be a resident of the same state as the specified relative or caretaker adult with whom the child is living.

[8.102.410.11 NMAC - Rp 8.102.410.11 NMAC, 7/1/2024]

8.102.410.12 NONCONCURRENT RECEIPT OF ASSISTANCE:

A. To be eligible for inclusion in a NMW benefit group, the individual cannot already be included in or receiving benefits from:

(1) another HCA cash assistance benefit group;

(2) an SSI grant;

(3) a tribal TANF program or BIA-GA program;

(4) a government-funded adoption subsidy program;

(5) a TANF program in another state; or

(6) foster care payments as defined in Title IV of the Social Security Act.

B. An individual may not be the payee for more than one NMW cash assistance payment.

C. Supplemental security income:

(1) Ongoing SSI eligibility: A person eligible for SSI on an ongoing basis is not eligible for NMW or refugee assistance benefits on the basis of concurrent receipt of assistance. The SSI recipient is not included in the benefit group for purposes of financial assistance eligibility and benefit calculation. The income, resources, and needs of the SSI recipient are excluded in determining benefit group eligibility and payment.

(2) SSI applicants: An individual receiving cash assistance benefits from the HCA may apply for and receive SSI benefits for the same months for which the HCA has already issued benefits. Cash assistance benefits issued by the HCA are considered in determining the amount of retroactive SSI benefits. NMW ineligibility or overpayments shall not be established for any month for which SSI issues a retroactive benefit. When verification is received that a benefit group member is approved for SSI on an ongoing basis, that member shall be immediately removed from the benefit group.

D. Subsidized adoptions: Children in receipt of state or federal adoption subsidy payments are included as benefit group members, and their income is counted in determining eligibility and payment.

E. Other HCA programs: Non-concurrent receipt of assistance limitations apply to HCA programs authorized in 8.102 NMAC, 8.106 NMAC, 8.119 NMAC, tribal TANF programs, SSI, and payments for foster care under

Title IV of the Social Security Act. SNAP, medicaid, LIHEAP and other similar programs are not considered concurrent assistance and shall not make an individual ineligible for cash assistance and tribal TANF programs.
[8.102.410.12 NMAC - Rp 8.102.410.12 NMAC, 7/1/2024]

8.102.410.13 WORK PROGRAMS: The NMW work program is designed to improve the participant's capacity to improve income and strengthen family support. If an individual who is required to meet work program requirements fails to do so, the benefit group may be subject to the payment sanctions described in 8.102.620.10 NMAC.
[8.102.410.13 NMAC - Rp 8.102.410.13 NMAC, 7/1/2024]

8.102.410.14 [RESERVED]
[8.102.410.14 NMAC Repealed, 8.102.410.14 NMAC, 7/1/2024]

8.102.410.15 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, SNAP, medicaid, or SSI in more than one state at the same time shall not be eligible for inclusion in the cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. Fugitive and probation and parole violators: An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole shall not be eligible for inclusion in the cash assistance benefit group.

C. Certain convicted felons: An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(1) aggravated sexual abuse under section 2241 of title 18, United States Code;

(2) murder under section 1111 of title 18, United States Code;

(3) an offense under chapter 110 of title 18, United States Code;

(4) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a); or

(5) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(6) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.
[8.102.410.15 NMAC - Rp 8.102.410.15 NMAC, 7/1/2024]

8.102.410.16 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, food stamps, medicaid, or SSI in more than one state at the same time shall not be eligible for inclusion in the cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. Fugitive and probation and parole violators: An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole shall not be eligible for inclusion in the cash assistance benefit group.
[8.102.410.16 NMAC - Rp 8.102.410.16 NMAC, 7/1/2024]

8.102.410.17 [RESERVED]
[8.102.410.17 NMAC - Rp 8.102.410.17 NMAC, 7/1/2024]

8.102.410.18 LIFETIME LIMITS:

A. NMW/TANF:

(1) NMW/TANF cash assistance shall not be provided to or for an adult or a minor head of household for more than 60 months during the individual's lifetime. The benefit group shall be ineligible if the benefit group contains at least one adult, minor head of household or spouse of the minor head of household who has received 60 or more months of NMW/TANF cash assistance, unless the lifetime limit has been waived pursuant to Subsection E of 8.102.410.17 NMAC.

(2) For purposes of determining the 60-month lifetime limit, the count of months of NMW/TANF cash assistance begins on July 1, 1997, and thereafter, and includes assistance received under PROGRESS, or the court-ordered AFDC program in effect until March 31, 1998, or NMW.

(3) Any month in which an adult, a minor head of household, or the spouse of a minor head of household, has received full, partial, prorated, or retroactive NMW/TANF cash assistance shall be considered a month of receipt and shall be counted towards the 60-month lifetime limit for the benefit group in which that individual resides.

(4) The count of months of NMW/TANF assistance shall include cash benefits, supportive services reimbursements, or other forms of benefits designed to meet a family's ongoing basic needs (for food, clothing, shelter, utilities, household goods, personal care items, and general incidental expenses). NMW/TANF cash assistance shall include supportive services such as transportation and childcare provided to a family who is unemployed.

(5) Receipt of TANF assistance from another state after July 1997, or from a tribal entity that does meet the criteria at Subsection C of 8.102.410.17 NMAC is counted as a month of receipt of TANF assistance for purposes of the term limit regulation.

B. Non-countable assistance:

(1) The HCA shall not count a month of receipt of NMW/TANF cash assistance or services toward the 60-month lifetime limit if the participant was a minor who was not the head of household or the spouse of the head of household.

(2)

Support services, transportation reimbursements, or child care assistance received by a benefit group with earned income shall not be considered as a month of NMW/TANF assistance against the 60-month term limit, as long as the benefit group does not also receive NMW/TANF cash assistance to meet ongoing basic needs.

(3) Assistance shall not be considered a month of NMW/TANF cash assistance if the assistance is a:

(a) non-recurrent short term benefit that will not extend beyond four months, is not intended to meet ongoing basic needs, and is designed to meet a specific crisis situation or episode of need;

(b) work subsidy to an employer to cover the cost of employee wages, benefits, supervision and training and does not use TANF funds;

(c) refundable earned income tax credit;

(d) contribution to or distribution from an individual development account;

(e) service such as counseling, case management, peer support, child care information and referral, transitional services, job retention, job advancement, or other employment related services that do not provide basic income support; and

(f) transportation benefit provided under a job access or reverse commute project to an individual who is not receiving NMW/TANF cash assistance.

(4) Under federal law, TANF funds may be transferred into the social services block grant and the child care development block grant. Benefits provided to individuals from these transferred funds are no longer characterized as TANF funds and do not count against the lifetime limits.

C. Excluded from the term limit count: Any month in which an adult or minor head of household receives NMW or tribal TANF cash assistance or services while residing in Indian country, as the term is defined in 18 U.S.C. subsection 1151, and where at least fifty percent of the adults are not working, shall not be counted toward the lifetime limit.

D. Extension of the term limit due to hardship: Up to twenty percent of the population of TANF participants to whom the term limit applies may be waived from the 60-month term limit based on hardship or being battered or subjected to extreme cruelty.

(1) An extension of NMW/TANF cash assistance shall not be granted to a benefit group prior to exhausting the 60-month lifetime limit.

(2) The term limit extension will end if the condition or situation allowing the extension ceases to exist.

E. Hardship extension types: For purposes of establishing a hardship and eligibility for an extension of NMW/TANF cash assistance, an individual to whom the lifetime limit applies must demonstrate through reliable medical, psychological or mental reports, social security administration (SSA) records, court orders, HCA records or police reports that the individual:

(1) is determined eligible for a limited work participation status due to one of the following qualifying conditions:

(a) an impairment, either temporarily or permanently, as determined by IRU in accordance with Paragraph (1) of Subsection C of 8.102.420 NMAC;

(b) is the sole provider of the care for an ill or incapacitated person;

(c) does not have the ability to be gainfully employed because the individual is affected by domestic violence;

(d) has been battered or subjected to extreme cruelty;

(2) has an application for supplemental security income (SSI) pending in the application or appeals process and:

(a) is currently granted a limited participation status because of a temporary or complete disability; or

(b) was granted a limited participation status because of a temporary or complete disability in the previous 24 months;

(3) has reached the age of 60 by the end of the last month of their term limit;

(4) is otherwise qualified as defined by the HCA.

F. Determining hardship and eligibility for an extension:

(1) The incapacity review unit shall make a determination of hardship based on a temporary or complete disability or being the sole provider of home care to an ill or disabled family member based on criteria set forth at 8.102.420.11, 8.102.420.12 and 8.102.420.13 NMAC.

(2) The incapacity review unit may determine contingency requirements or conditions for continued participation of the individual under the applicable hardship type(s).

(3) Hardship based on domestic violence, battery, or extreme cruelty: A certification that an individual cannot be gainfully employed due to domestic violence, or has been battered or subject to extreme cruelty shall be made by a trained domestic violence counselor and shall be part of the case record.

(a) Supporting documentation shall be provided to the HCA and made part of the individual's case record. For purposes of determining a hardship, an individual has been battered or subjected to extreme cruelty if the individual can demonstrate by reliable medical, psychological or mental reports, court orders, HCA records or police reports that the individual has been subjected to and currently is affected by:

(i) physical acts that result in physical

injury;
(ii) sexual abuse;
(iii) being forced to engage in non-consensual sex acts;
(iv) threats or attempts at physical or sexual abuse;
(v) mental abuse; or
(vi) neglect or deprivation of medical care except when the deprivation is based by mutual consent on religious grounds.

(b) The incapacity review unit shall review the documentation provided to demonstrate a hardship type related to domestic violence, battery, or extreme cruelty, shall ensure that the documentation supports a finding of hardship, and shall determine review periods and contingency requirements if applicable.

(4) The HCA shall determine the eligibility of the individual for a hardship extension based on age or whether an application for SSI is pending or in the appeals process by reviewing HCA records or SSA files.

G. Participating benefit group:

(1) A NMW benefit group in active status at the time the benefit group reaches the 60-month term limit may ask for an extension of NMW/TANF cash assistance under hardship provisions. The benefit group must provide supporting documentation by the 15th day of the 60th month. If otherwise eligible and a hardship type is determined, the benefit group shall be authorized cash assistance from the first day of the 61st month.

(2) A NMW benefit group whose certification period expires in the 60th month of the term limit may be recertified, if otherwise eligible, under hardship provisions, but must provide supporting documentation by the end of the benefit group's certification period.

H. Closed benefit group: A benefit group shall be required to file an application for NMW cash assistance based on hardship under the following conditions:

(1) a NMW benefit group in active status does not submit supporting documentation by the 15th day of the 60th month of receipt of cash assistance; or

(2) a NMW case closes upon reaching the term limit;

(3) a benefit group may file an application on the first day of the 61st month, or at any time after, and if eligible, benefits shall be approved effective the date of authorization or 30 days from the date of application, whichever is earlier.

I. Automatic extension of cash assistance: A NMW benefit group shall be automatically extended NMW/TANF cash assistance based on hardship when the benefit group member who has received 60 months of cash assistance is:

(1) an adult age 60 or over; or

(2) an adult or minor head of household with an application for SSI pending or in the appeals process; or based on verification in the case record that is not older than three months, the benefit group member is:

(3) granted a limited participation status due to a complete disability, either permanently or temporarily;

(4) granted a limited participation status due to being the sole provider of home care to an ill or disabled family member; or

(5) unable to be gainfully employed because the benefit group member has been battered or subjected to extreme cruelty, or affected by domestic violence; or

(6) is otherwise qualified as defined by the HCA.

[8.102.410.18 NMAC - Rp 8.102.410.18 NMAC, 7/1/2024]

8.102.410.19 REQUIREMENTS FOR TANF HARDSHIP EXTENSIONS:

A. Benefit group: NMW cash assistance regulations at 8.102 NMAC continue to apply to a NMW/TANF benefit group that receives a cash assistance based on a hardship determination. A benefit group may be sanctioned at the appropriate level in compliance with regulations at 8.102.620.10 NMAC when a benefit group member fails to comply with the requirements at set forth in at 8.102.410.17 NMAC and 8.102.410.18 NMAC.

B. Certification period: In most cases the certification period for the case will be set at six months, beginning with the 61st month of cash assistance. The incapacity review unit may set the certification period for a benefit group that is shorter or longer than six months when the condition for the hardship type warrants such a determination.

C. Limited work participation status individuals:

(1) An individual granted an extension of the 60-month term limit due to a hardship determination shall be required to meet with the work program contractor. The individual shall be referred by the HCA to the work program contractor:

(a) no later than the first day of the 61st month for a case in active status in the 60th month; or

(b) by the end of the first month of the benefit group's hardship extension period for a benefit group whose certification period expires in the 60th month; or

(c) upon approval of a hardship extension period for a benefit group whose case is closed.

(2) An individual granted an extension of the 60-month time limit shall be required to comply with the limited work participation hours as determined by the IRU under hardship, including but not limited to, counseling; substance abuse treatment; speech or physical

therapy, continuing or follow up medical treatment; keeping doctor's appointments; family counseling; or engaging in programs or activities to address the hardship type.

D. Other benefit group members: Any other individual included in the NMW benefit group must comply with NMW compliance requirements set forth at 8.102.460 NMAC.

E. Case management:

(1) The individual and the work program contractor shall develop a case management plan that includes specific provisions for assessing barriers and determining actions or behaviors that will enhance the ability of the benefit group to become economically independent.

(2) Case management includes, but is not limited to:

(a) making referrals to appropriate agencies and providing any follow up necessary to obtain the assistance needed by the benefit group;

(b) completing an in-depth assessment and identifying individual and family barriers, such as but not limited to, learning disabilities, cognitive disabilities, substance abuse, criminal history, transportation issues, child care, school attendance for dependent children, limited English proficiency; or limited work ability;

(c) making appropriate referrals and seeking the assistance needed to address the barriers;

(d) identifying support services needs; or

(e) placement in appropriate and realistic work activities and follow up on work activity progress.

[8.102.410.19 NMAC - Rp 8.102.410.19 NMAC, 7/1/2024]

History of 8.102.410 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 221.9000, Registration for Manpower Services, Training and Employment Under the Work Incentive Program, 3/24/1980.
ISD FA 310, Non-Financial Eligibility Criteria, 2/9/1988.
ISD FA 350, Work Registration, 2/10/1988.
ISD FA 350, JOBS, 6/25/1990.
ISD 221.7000, Deprivation of Parental Support, 3/6/1980.
ISD FA 320, Deprivation of Parental Support, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.410 NMAC Recipient Policies - General Recipient Requirements - Repealed, 07/01/2001.
8.102.410 NMAC - Recipient Policies - General Recipient Requirements (filed 6/18/2001) - Repealed, effective 7/1/2024.

Other: 8.102.410 NMAC - Recipient Policies - General Recipient Requirements (filed 6/18/2001) Replaced by 8.102.410 NMAC - Recipient Policies - General Recipient Requirements, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 420 RECIPIENT POLICIES - SPECIAL RECIPIENT REQUIREMENTS

8.102.420.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.420.1 NMAC - Rp 8.102.420.1 NMAC, 7/1/2024]

8.102.420.2 SCOPE: The rule applies to the general public.
[8.102.420.2 NMAC - Rp 8.102.420.2 NMAC, 7/1/2024]

8.102.420.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.420.3 NMAC - Rp 8.102.420.3 NMAC, 7/1/2024]

8.102.420.4 DURATION: Permanent.
[8.102.420.4 NMAC - Rp 8.102.420.4 NMAC, 7/1/2024]

8.102.420.5 EFFECTIVE DATE: July 1, 2024, unless a later

date is cited at the end of a section.
[8.102.420.5 NMAC - Rp 8.102.420.5 NMAC, 7/1/2024]

8.102.420.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.
[8.102.420.6 NMAC - Rp 8.102.420.6 NMAC, 7/1/2024]

8.102.420.7 DEFINITIONS: [**RESERVED**]
[8.102.420.7 NMAC - Repealed, 8.102.420.7 NMAC, 7/1/2024]

8.102.420.8 AGE - NMW: To be eligible for inclusion in the benefit group, a dependent child is a natural child, adopted child or stepchild or ward who is:

A. 17 years of age or younger;

B. 18 years of age and is enrolled in high school; or

C. between 18 and 22 years of age and is receiving special education services regulated by the New Mexico public education department (PED).
[8.102.420.8 NMAC - Rp 8.102.420.8 NMAC, 7/1/2024]

8.102.420.9 SCHOOL ATTENDANCE:

A. Requirement: A child of school age, as defined by PED, must attend school and have satisfactory attendance to meet the personal responsibility requirements of the parent, specified relative, or caretaker.

B. Student status:

(1) A dependent child of school age must be a full-time student at a certified educational facility or participating and fully complying with a home-schooling program approved by the New Mexico PED. School age means any dependent child who turns six years of age prior to September first and is under 18 years of age.

(2) A participant who is 18 years of age may be included in the NMW benefit group if the individual is enrolled in high school, or the high school equivalent level of vocational or technical training. Such an individual may be eligible to be included in the NMW benefit group until the end of the month in which the individual graduates or until the end of the month in which the individual turns 19 years of age, whichever occurs first.

(3) A student who is between 18 and 21 years of age may be included in the NMW benefit group as long as the student is enrolled in high school and is receiving special education services regulated by the PED. There must be a current valid individual education plan (IEP) for the student to verify the special education services.

(4) A dependent child age 17 years of age or younger who has graduated from high school or has obtained a GED shall be deemed to be a full-time student and to fulfill attendance requirements.

(5) A minor unmarried parent who does not have a child under the age of 12 weeks, must attend school full time to obtain a high school diploma or must participate in a GED program full-time or participate in approved alternate schooling unless the minor unmarried parent has already graduated from high school or obtained a GED.

C. School attendance:

(1) Full time attendance: A child is considered a full-time student based on the below criteria:

(a) School attendance is defined by the standards of the educational facility or program in which the child is enrolled including regularly scheduled vacations and breaks provided the child:

(i) has not been removed for non attendance; and

(ii) resumes attendance when classes start again;

(b) is currently enrolled in a home schooling programming approved by the New Mexico PED.

(2) Verification:

(a) Verification of school attendance must be provided at time application and certification for any:

(i) minor unmarried parent; and

(ii) dependent child 18 years of age and over.

(b) The statement of the parent or caretaker is acceptable verification of school attendance for all other dependent children, unless otherwise questionable.

D. Unsatisfactory attendance:

(1) A child shall be considered not meeting the school attendance requirement when the child:

(a) is not enrolled in school;

(b) has accumulated three unexcused absences in a grading period, but not on the same day;

(c) has dropped out of school during the current grading period; or

(d) has one or more unexcused absences during the time period covered by a current school attendance plan.

(2) Reporting requirement: Within 14 days of the date it becomes known, the parent, specified relative, or caretaker must report to ISD if a child is not enrolled in school, has accumulated three unexcused absences during the current grading period, or has dropped out of school. Failure to report that a child has not met school attendance requirements shall not result in a non-reporting sanction for the parent, or the specified relative or caretaker if included in the benefit group.

(3) Failure to meet: In the absence of good cause for failure to meet the school attendance requirements the conciliation process shall be initiated.

(a) Conciliation process: Prior to removing the child's needs from the benefit group's standard of need, the parent, specified relative or caretaker shall have a 10 working day conciliation period to address school non-attendance. The conciliation period is a 10 working day period affording an opportunity for the parent, child, and the school to develop a plan to ensure regular attendance by the child and comply with NMW requirements.

(i) Within 10 days of receipt of verification that a child has not met school attendance requirements, the caseworker shall take action to initiate a conciliation period by issuing a notice of action.

(ii) The benefit group shall have 10 working days from the date of issuance of the notice to provide a school attendance plan indicating the school's confirmation of satisfactory arrangements.

(iii) If a benefit group fails to provide a school attendance plan, a notice of adverse action shall be sent within five working days.

(iv) If the school confirms that satisfactory arrangements have been made to ensure regular attendance by the child, the child shall remain eligible.

(b) Benefit reduction:

(i) The child shall be removed from the benefit group effective the month following the month the notice of adverse action expires.

(ii) If there is one or more unexcused absence following successful submission of a school attendance plan (the school's confirmation of satisfactory arrangements), the caseworker shall remove the child from the benefit group effective the month following the month the notice of adverse action expires.

(c) Case closure: If the child is the only child included in the benefit group, the cash assistance case shall be subject to closure in the month following the notice of adverse action.

(4) Good cause: A child with unsatisfactory school attendance or enrollment shall be warranted good cause based on the following circumstances:

(a) periods of personal illness or convalescence;

(b) family emergencies, for a period not to exceed 30 days;

(c) participation in or attendance at cultural and religious activities as long as the child has parental consent; or

(d) a minor parent has a child under 12 weeks of age.

E. Regaining eligibility: Once a child has been removed from the benefit group due to failure to comply with school attendance requirements, the child can not be considered a member of any benefit group. Changes in school attendance must be reported by the parent/caretaker. Eligibility may be regained when:

(1) the child has attended school with no unexcused absences for the 30 days;

(2) circumstances of good cause apply as listed in Paragraph (4) of Subsection D; or

(3) during the summer months if the child is promoted, attending summer school or graduating.

[8.102.420.9 NMAC - Rp 8.102.420.9 NMAC, 7/1/2024]

8.102.420.10 [RESERVED]

8.102.420.11 NMW/TANF LIMITED WORK PARTICIPATION STATUS DETERMINATION PROCESS

A. Eligibility: To be eligible for a limited work participation status, a participant must meet at least one of the criteria below as verified by the HCA:

(1) Who is age 60 or older.

(2) A single parent, not living with the other parent of a child in the home, or caretaker relative with no spouse, with a child under the age of 12 months. A participant may be eligible for a limited work participation status using this qualification for no more than 12 months during the participant's lifetime.

(3) A single custodial parent caring for a child less than six years of age or who is a medically fragile child if the parent is unable to obtain child care for one or more of the following reasons and the children, youth and families department (CYFD) certifies as to the unavailability or unsuitability of child care:

(a) the unavailability of appropriate child care within a reasonable distance from the parent's home or work site; or

(b) the unavailability or unsuitability of appropriate and affordable formal child care by a relative or under other arrangements; or

(c) the unavailability of appropriate and affordable formal child care by a relative or under other arrangements;

(4) A participant who is a woman in her third trimester of pregnancy, or six weeks post partum.

(5)

A participant whose personal circumstances preclude participation for a period not to exceed 30 consecutive days in a calendar year.

(6) A participant who demonstrates by reliable medical, psychological or mental reports, court orders, police reports, or personal affidavits (if no other evidence is available), that family violence or threat of family violence effectively bars the parent from employment.

(7) A participant who is completely impaired, either temporarily or permanently, as determined by IRU.

(8) A participant may be entitled to the family violence option (FVO). This option allows for a parent in a domestic violence environment to be in a limited work participation status for the length of time certified by a trained domestic violence counselor. The certification shall indicate that the parent is in a domestic violence environment which makes them eligible for a limited work participation status.

(a) A participant's FVO limited work participation status shall be reviewed every six months and shall be determined by IRU based on the domestic violence counselor's certification.

(b) A participant who can continue to comply with work requirements as certified by a trained domestic violence counselor may be eligible for a limited work participation status for 24 weeks as described in 8.102.461.15 NMAC.

(9) A participant who is the sole provider of the care for an ill or incapacitated person. In order to meet this exception, the participant must show that the parent is the sole caretaker for a disabled person and must demonstrate that the participant cannot be out of the home for the number of hours necessary to meet standard work participation hours. The following apply to caretaker conditions in determining if the standard work participation rate applies or if a limited work participation rate will be granted:

(a) Only those care activities around which work program activities cannot be scheduled are taken into consideration.

(b) Food purchase and preparation activities, home maintenance chores, etc. are activities which may be scheduled and performed at time other than work program participation hours and are not taken into consideration when determining the standard work participation rate.

(c) A requirement to be on call for the medical emergencies of a medically fragile person is taken into consideration in determining the standard work participation rate for the participant.

(10) A participant may demonstrate good cause for the need for the limited work participation status. A good cause limited work participation status may exist and shall be determined by the HCA based on the participant's existing condition(s) to include any barriers identified during the NMW assessment process that impair an individual's ability to comply with the standard work participation rate or capacity to work.

B. Determinations in general: The NMW/TANF determination for a limited work participation status is made independently of and using differing standards from those used for determining OASDI or SSI eligibility, general assistance, workman's compensation, veteran's compensation or in Americans with Disability Act (ADA) determinations. Medical and social information (as appropriate) used by the HCA's reviewers may differ between determinations for each type of program, and a participant's condition may improve or worsen over time. As a result, a participant may be classified disabled by one program, but not by another. A disability determination made for another program or purpose is immaterial to the NMW/TANF limited work participation status determination. NMW/TANF determinations shall be made by applying NMW/TANF regulations and medical and non-medical information (as appropriate) known to the HCA. An applicant/participant may have more than one condition to qualify for limited work participation status. The limited work participation rate and work activities will reflect accommodations for all identified and approved qualifying conditions.

C. Medical and non-medical based determinations:

(1) Medical conditions: The IRU shall review all documentation and make determinations for participants requesting a limited work participation status or hardship extension due to a medical condition. To be eligible for a limited work participation status from or for a hardship extension, based on a medical condition, the HCA must find:

(a) evidence of a physical or mental impairment(s) supported by medical documentation; and

(b) determine that the severity of the impairment(s), as supported by appropriate medical documentation is sufficient to significantly restrict the participant's capacity to fulfill the standard work participation rate or capacity to work; requests for limited work participation status or hardship extension must be supported by medical documentation, but may be supplemented by non-medical documentation provided by the applicant as requested by the IRU.

(2) Caretaker conditions: The IRU shall review all documentation and make determinations for participants requesting a limited work participation status or hardship extension due to caretaker conditions. To be eligible for a limited work participation status or for a hardship extension, as a caretaker, the HCA must find the participant is:

(a) the sole provider for an ill or incapacitated family member living in the home who does not attend school on a full time basis; and

(b) providing necessary care to the extent that otherwise precludes the participant's capacity to fulfill standard work participation rates or capacity to work.

(3) Non-medical conditions: The NMW service provider shall review documentation and make determinations regarding requests for limited work participation status for non-medical conditions. If a participant has a medical condition(s) in addition to non-medical conditions, the IRU shall review documentation and make determinations regarding requests for limited work participation status for medical and non-medical conditions. To be eligible for a limited work participation status from the NMW/TANF standard work participation rate based on conditions that are not medical in nature, the HCA must find the participant has one of the qualifications for a limited work participation status identified in Subsection A above.

D. Case development process: The caseworker shall be responsible for explaining hardship eligibility, work program requirements, standard work participation rates, and for referring all participants requesting a limited work participation status and hardship extensions to the IRU and NMW service provider, as appropriate. Participants must complete and return the requested information to request a limited work participation status within 30 days of the request.

(1) Limited work participation status requests for medical conditions: Requests for a limited work participation status based on a medical condition shall be sent to the IRU for determination and contain the following:

(a) a completed assessment that has been conducted by the NMW service provider within the six months prior to the date of the request for a change in status;

(b) a completed individual responsibility plan conducted by the NMW service provider;

(c) copies of relevant medical reports made within the last six months;

(d) a work participation agreement with the proposed activity(ies); and

(e) additional documents for evidence of other work related factors.

(2) Limited work participation status requests for non-medical conditions: The NMW service provider shall utilize the following documents to determine eligibility for the limited work participation status:

(a) a completed assessment that has been conducted by the NMW service provider within the six months prior to the date of the request for a change in status; and

(b) a completed individual responsibility plan conducted by the NMW service provider.

E. Provision of documentation: It shall be the responsibility of the participant requesting limited work participation status or hardship extension to provide recent (within the last six months) medical and non-medical information necessary to make a determination. Non-medical evidence will not be considered in the absence of medical documentation for requests based on medical conditions. A participant, who has not provided the necessary information as requested by the HCA, contractor or its designee to make a determination within 30 days of the request for the limited work participation status or hardship extension, shall be subject to meeting full participation requirements. Participants who fail to provide the requested documentation within 30 days of the request, but are also eligible for a limited work participation status on the basis of a non-medical condition, shall be referred to the NMW service provider to determine the limited work participation status based on the non-medical condition. The participant is not responsible for providing documentation produced by the HCA, its contractors, or its designee.

(1) Medical documents: Written paperwork must be submitted to verify the existence of physical, mental impairment(s) or both; as well as the extent of the caretaking needs. It is the responsibility of the participant to get all information to the IRU for review. Determinations are based on the written evidence provided in a timely manner to IRU.

(a) Source: Medical documents must be obtained from approved source(s), limited to: medical doctors, physician assistants, doctors of osteopathy or podiatry, ophthalmologists, psychiatrists or psychologists, state-licensed providers, and individuals that meet the minimum mental health professional qualifications set by their community mental health services employer.

(b) HCA assistance: The HCA, contractor or its designee shall offer assistance to the participant to include obtaining medical documents or other reasonable accommodations as requested by the participant. If the HCA is assisting the participant with obtaining documentation or other accommodation, the participant is still responsible for providing accurate and timely information.

(c) Timeliness of report: The participant shall provide medical records from the past six months. Medical documents over six months old from the date of the request for the limited work participation status or hardship extension may be useful to support a pattern of recurring impairment, but must be accompanied by current medical documents.

(d) Independent medical review: The HCA may request additional documentation in order to make

a determination regarding a participant's request for limited work participation status. The IRU may request additional documentation in the form of an independent medical review of the participant's condition(s). If the participant is also a recipient of medicaid, the HCA may assist with a referral to a medicaid provider, as appropriate.

(2) Non-medical information: Non-medical information may not be used for medical condition determinations without the provision of medical documents. Non-medical information may be submitted to the IRU or the NMW service provider and will be considered if the source is public and private agencies, schools, participants and caregivers, social workers and employers, and other relevant and independent sources to assist in the determination of whether the barriers are of sufficient severity to restrict the participant's capacity to fulfill the standard work participation rate, or that the need to care for an individual are so great as to limit or exclude participation.

F. Case disposition:

(1) Medical based conditions: The IRU shall have sole responsibility for reviewing all medical documents. When making a determination regarding a participant's capacity to fulfill the standard work participation hours, the IRU will within 30 calendar days of receipt complete the following:

(a) conduct a thorough review of the documentary evidence;

(b) make a determination as to whether a medical condition or caretaking need is supported by the evidence provided by the participant;

(c) determine the anticipated duration of the impairment;

(d) adopt or propose participation activities based on the work participation agreement submitted with the participants request packet; and

(e) establish the reduced limited work participation hours if a limited work participation status or hardship extension of the 60 month time limit is granted.

(2) Non-medical based impairments: The NMW service provider shall review all non-medical information and make a determination that a participant is eligible for a limited work participation status. The determination shall identify one of the criteria qualifying for a limited work participation status. The NMW service provider shall identify the non-medical barrier and establish the participation activity(ies) and the limited work participation rate to be included in the approved work participation agreement. All of the non-medical information is considered in assessing the participant's capacity to fulfill the standard work participation rate. Case disposition shall include:

(a) a thorough review of documentary evidence;

(b) a determination as to whether the claim of a non-medical impairment is supported; and

(c) the anticipated duration of the impairment.

(3) Duration of condition(s): The duration of the condition shall be evaluated based on documentation provided and must be expected to last at least 30 days in order to grant a limited work participation status.

(4) Evaluation of medical report(s): Reports shall be reviewed by the IRU for completeness and detail sufficient to identify the caretaking needs, limiting effects of impairment(s), probable duration of the impairment(s), and capacity to perform work program participation standards.

(a) Anatomical and physiological reports shall be reviewed for a description of the medical history, clinical findings, laboratory findings, diagnosis, prescribed treatment and prognosis, and to identify the participant's ability to sit, stand, move, lift, carry, handle objects, hear, speak and travel.

(b) Psychological assessments shall be reviewed for a description of the participant's behavior, affect, orientation, capacity for appropriate decision-making, response to stress, cognitive function (awareness, memory and intellectual capacity), contact with reality and need for occupational, personal and social adjustment(s).

G. Notification: The HCA shall notify the participant regarding the disposition of their request for limited work participation status in compliance with the requirements of adequate notice and notice of adverse action, as applicable.

H. Re-evaluation of status: A participant's limited work participation status shall be re-evaluated on a periodic basis, as determined by the IRU or the NMW service provider, as appropriate. At the time of reevaluation, it shall be necessary to get an update of the medical or non-medical impairment, caretaking need, and any changes in other work-related factors. The IRU shall remain responsible for deciding whether a medical impairment or caretaking need still exists, and the date of the next re-evaluation for continued approval of limited work participation status. The NMW service provider shall remain responsible for deciding whether the non-medical impairment still exists and the date of the next evaluation for continued approval of limited work participation status.

I. Determining the limited work participation rate: after a participant is approved for limited work participation status either at the initial determination or re-evaluation, the IRU or NMW may prescribe conditional work program activities and requirements designed to assist the participant to help accommodate and eliminate barriers. The participant may be assigned to core, non-core and other activities which may include, but not be limited to, one of the

contingencies below:

(1) follow treatment plans as prescribed by a physician or mental health provider;

(2) seek and utilize available community based resources;

(3) accept treatment as recommended by a physician or mental health provider;

(4) pursue a referral for DVR, or other available services;

(5) apply for SSI, if applicable; or

(6) any other activity specific to the participant's circumstance and conditions.

J. Transition of currently waived participants to the limited work participation status:

(1) Currently waived: Participants who are waived on or before the effective date of this regulation shall be evaluated for a limited work participation status at their next recertification for TANF benefits or at the next waiver review, whichever is earlier.

(2) Pending waiver determination: Participants who are pending a waiver determination on or before the effective date of this regulation shall be considered for a waiver of the work participation status. They will be determined for a limited work participation status at their next recertification for ongoing TANF benefits or at the next waiver review, whichever is earlier.

[8.102.420.11 NMAC - Rp, 8.102.420.11 NMAC, 7/1/2024]

8.102.420.12 ASSESS CAPACITY FOR WORK

A. General: A medical or mental health condition that precludes a participant's capacity to fulfill the standard work participation rate or capacity to work shall be determined by evaluating the extent of the impairment and other work-related factors. A participant is eligible for a limited work participation status if there is a determination of impairment or condition by the IRU or NMW service provider, as appropriate.

B. Capacity to perform NMW program participation standards: If the participant is determined by IRU or the NMW service provider to have an impairment, the other work-related factors shall be considered. Although a participant may be determined to have some type of impairment, the existence of impairment does not necessarily result in a finding that the participant is incapable of fulfilling the standard work participation hours. A determination that a participant is a caretaker does not necessarily result in a finding that the need to care for an incapacitated or ill household family member is so great as to limit or exclude participation. Many participants with impairments are able to work and thus are not considered to have a medical condition requiring the granting of a limited work participation status according to the standards set forth in the NMW program.

(1) Sedentary work: Sedentary work involves lifting no more than ten pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and sedentary standards are met.

(2) Light work: Light work involves lifting no more than twenty pounds at a time, with frequent lifting or carrying of objects weighing up to ten pounds. Even though the weight lifted may be very little, a job is placed in this category if it requires a good deal of walking or standing, or if it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities

(3) Medium work: Medium work involves lifting no more than 50 pounds at a time, with frequent lifting or carrying of objects weighing up to 25 pounds.

(4) Heavy work: Heavy work involves lifting no more than 100 pounds at a time, with frequent lifting or carrying of objects weighing up to 50 pounds.

(5) Very heavy work: Very heavy work involves lifting objects weighing more than 100 pounds at a time, with frequent lifting or carrying of objects weighing 50 pounds or more.

C. Psychological impairment: If psychological impairment is being assessed, a participant's mental ability to function at one of the above-mentioned levels shall be evaluated in the following areas:

(1) Judgment: A participant's ability to exercise appropriate decision-making processes in a work situation consistent with the participant's abilities.

(2) Stress reaction: Participant's ability to handle stress consistent with the level of employment.

(3) Cognitive function: Participant's awareness, memory, intellectual capacity and other cognitive functions.

D. Capacity for gainful employment: A participant's verified employment status shall be taken into consideration in determining impairment based on the type, nature, and duration of employment. Impairment may still be determined where the participant is employed minimally or for rehabilitative purposes.

(1) Minimal employment: An individual who is minimally employed may still be considered impaired if the individual cannot reasonably be expected to be self-supporting by at least the standard of need for the size of the benefit group.

(2) Rehabilitative employment: Work made available to an individual through the interest or compassion of others, or to rehabilitate an individual (as in a sheltered workshop), but which would not ordinarily exist

on the open labor market, shall not be considered employment in an impairment determination.

E. Other work-related factors: Impairments together with other work-related factors may be considered to establish the participant's capacity to perform basic work program participation standards and engage in gainful employment. While these factors may present an impediment to obtaining employment, they are problems which can be overcome through work program participation. Where such impediments exist, the participant shall be expected to participate in activities which will overcome these barriers. Other work-related factors include but are not limited to the following:

(1) Language barriers: A participant's ability to speak, read, and write English.

(2) Educational level:

(a) Illiteracy: Inability to read or write English. Illiterate individuals are considered suitable for the general labor work force.

(b) Marginal: Eight years of education or less. Marginally-educated individuals are considered suitable for the semi-skilled work force.

(c) Limited: Lack of a high school diploma or GED, but more than eight years of education. Individuals with limited education are considered suitable for the semi-skilled to skilled work force.

(d) High school, GED and above: Indicates an individual's ability to compete in all levels of the job market.

(e) Training program: Completion of training in a particular field of employment may offset limited education in some instances.

(3) Job experience: Experience in a job field can overcome a lack of education, training or both. Jobs held in the last ten years shall be considered. Work experience shall be evaluated based on the type of work previously performed, the length of employment, and the potential for transferring the experience to other types of employment. Inability to continue working in one's prior field of work does not constitute a disability. Job experience is classified in the following categories.

(a) General labor: Does not require the ability to read or write.

(b) Semi-skilled labor: Requires a minimal ability to read, write and do simple calculations.

(c) Skilled labor: Ability to do work in which the ability to read, write and do calculations of a complex nature is needed. Specialized training in the area is also considered.

(4) Appearance: An individual's appearance is generally not the sole reason for an impairment determination. On rare occasions, impairment is disfiguring and may interfere with employment.

(5) Age: Age may affect participants with impairments. The older an individual is, generally, the harder it is for the person to overcome or recover from impairment. A participant's age may be considered when determining the extent of impairment and the support needed to assist a participant.

F. WPA following IRU determination of limited work participation status: After the IRU or NMW service provider, as appropriate, makes a determination to either grant or deny a request for a limited work participation status, the participant must act in accordance with the paragraphs below to ensure they are in compliance .

(1) Limited work participation status granted and adoption of the WPA: Upon approval for the limited work participation status, the participant shall continue to continue to participate in the assigned core or non-core activities or contingencies identified on the WPA submitted to IRU for determination. The WPA shall be considered finalized and the participant shall follow the WPA until the next evaluation date determined by the IRU or NMW service provider.

(2) Limited work participation status granted and modification of the WPA: If the participant is approved for a limited work participation status, but the IRU did not accept the WPA, the participant and the NMW service provider shall meet no later than 15 days following date of the limited work participation status approval to modify the WPA in accordance with the determination of the IRU. The modification will take into consideration the participant's impairment(s) and provide a limited work participation rate and suggested core and non-core work activities.

(3) Limited work participation status denial: If the IRU or NMW service provider, as appropriate, denies the participant's request for limited work participation status, the participant is required to develop a WPA with the NMW service provider no later than 15 days following the date of denial by the IRU or the NMW service provider. Failure to develop a WPA may be considered non-compliance in accordance with 8.102.460 NMAC.
[8.102.420.12 NMAC - Rp, 8.102.420.12 NMAC, 7/1/2024]

8.102.420.13 [RESERVED]
[8.102.420.13 NMAC - Repealed, 8.102.420.13 NMAC, 7/1/2024]

8.102.420.14 CHILD SUPPORT:

A. Assignment: By state statute, Subsection F of Section 27-2-28 NMSA 1978, any participant who signs an application automatically assigns the participant's child support rights to the HCA. The assignment shall be made with respect to the child for whom NMW is provided and shall be valid as long as the participant receives NMW payments on the child's behalf. The assignment shall also include any spousal support for which the applicant is or may become eligible.

B. Cooperation:

(1) The adult responsible for each child included in the benefit group must cooperate with the child support services division (CSSD) in obtaining child support for any dependent child included in the NMW benefit group. Failure to do so will result in payment sanctions. The adult shall be required to cooperate regardless of whether the adult is included in the benefit group.

(2) Failure to cooperate shall result in the personal ineligibility of the participant refusing to cooperate and in a payment sanction against the benefit group, as described in 8.102.620.10 NMAC.

(3) The determination as to whether the participant has cooperated with CSSD shall be made by CSSD based on CSSD requirements. The cooperation requirement may be partially or fully waived by CSSD upon demonstration of good cause by the specified relative as indicated in Subsection E of 8.102.420.14 NMAC.

(4) The caretaker relative must transmit to CSSD any child support, spousal or medical support payment which the caretaker relative receives directly.

C. Determining that cooperation exists: A caretaker relative who, on the application and certification forms, indicates a willingness to cooperate and who provides basic information determined by CSSD as necessary to establish and pursue support shall be considered to have met the cooperation requirement until such time as CSSD reports to the caseworker that the participant is failing to cooperate.

D. Action upon receiving notice of noncompliance: On notification by CSSD of failure to cooperate, the caseworker shall take immediate action to issue a conciliation notice or to impose a noncompliance sanction.

E. Good cause:

(1) In some situations, it is not in the best interests of the child or parent to pursue support or to require that the caretaker relative cooperate with CSSD in pursuing such support. Caretaker relatives therefore must be:

(a) notified that the requirement to cooperate may be waived;

(b) informed of the requirements involved in the waiver; and

(c) given an opportunity to request a waiver that would exempt them from the cooperation requirement.

(2) If a caretaker relative requests a waiver of the cooperation requirement, assistance shall not be delayed pending determination of good cause, nor may enforcement of support begin or continue while the waiver of the requirement is under consideration. An applicant who makes a waiver request shall not be included in the benefit group until the necessary corroborative information and documents are provided to ISD.

(3) Granting a good cause exemption: The decision whether to grant a good cause exemption shall be made according to the following methods.

(a) Domestic violence exemption: Exemption status shall be reviewed based on the following criteria.

(i) The New Mexico family violence option in the NM TANF state plan allows for exemption from cooperation with CSSD requirements due to a domestic violence environment. The ISD caseworker shall exempt a participant from cooperation requirements with CSSD where a trained domestic violence counselor has certified that cooperation would make it more difficult to escape the domestic violence or would unfairly penalize the participant in light of current experiences.

(ii) CSSD shall exempt a participant from cooperation requirements with CSSD when the participant has demonstrated by reliable medical, psychological or mental reports, court orders or police reports that they are subject to or at risk to domestic violence.

(iii) Upon approval of exemption the caseworker shall submit a memo regarding exemption status to CSSD and ISD central office.

(b) Other good cause exemptions: All other good cause exemptions, including but not limited to and exemption due to a domestic violence environment that is not certified by a trained domestic violence counselor, from cooperation with CSSD requirements shall be made by the director of the CSSD or designee.

(4) Notification:

(a) Approval: The caseworker shall send a written notice to the client whether the waiver has been granted and when it will be reviewed. The letter shall also tell the client whether CSSD has determined that support can be pursued without danger or risk to the client or child.

(b) Denial: If CSSD decides that good cause does not exist, the caseworker shall notify the client that the request has been denied and that the client is expected to cooperate fully in pursuing support, within 10 working days of the day the notice was issued. The notification shall also inform the client that a client has 60 days in which to request an administrative hearing, but that the client is expected to begin cooperating within 10 days after the date of the letter.

[8.102.420.14 NMAC - Rp 8.102.420.14 NMAC, 7/1/2024]

8.102.420.15 [RESERVED]
[8.102.420.15 NMAC - Repealed, 8.102.420.15 NMAC, 7/1/2024]

8.102.420.16 SSI STATUS: Any individual who is potentially eligible for SSI on the basis of either age or disability must apply for and accept SSI. An individual receiving SSI, or who would be receiving SSI except for recovery of an overpayment, is not eligible to be included in an NMW, or an EWP benefit group.
[8.102.420.16 NMAC - Rp

8.102.420.16 NMAC, 7/1/2024]

8.102.420.17 [RESERVED]
[8.102.420.17 NMAC - Rp 8.102.420.17 NMAC, 7/1/2024]

History of 8.102.420 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 223.3000, Good Cause for not Cooperating in the Pursuit of Child Support, 3/28/1980.
ISD FA 330, Child Support, 2/10/1988.
ISD FA 340, GA Disability, 2/10/1988.
ISD FA 340, GA Disability, 8/30/1994.
ISD FA 310, Non-Financial Eligibility Criteria, 2/9/1988.
ISD 221.7000, Deprivation of Parental Support, 3/6/1980.
ISD FA 320, Deprivation of Parental Support, 2/10/1988.
ISD FA 850, State Supplement for Residential Care, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.420 NMAC Recipient Policies - Special Recipient Requirements - Repealed 07/01/2001.
8.102.420 NMAC - Recipient Policies - Special Recipient Requirements (filed 6/18/2001) - Repealed, effective 7/1/2024.

Other: 8.102.420 NMAC - Recipient Policies - Special Recipient Requirements (filed 6/18/2001) Replaced by 8.102.420 NMAC - Recipient Policies - Special Recipient Requirements, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 500 ELIGIBILITY POLICY - GENERAL INFORMATION

8.102.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.500.1 NMAC - Rp 8.102.500.1 NMAC, 7/1/2024]

8.102.500.2 SCOPE: The rule applies to the general public.
[8.102.500.2 NMAC - Rp 8.102.500.2 NMAC, 7/1/2024]

8.102.500.3 STATUTORY AUTHORITY:
A. 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.
B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.
C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.
D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.
E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.
F. 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.
[8.102.500.3 NMAC - Rp 8.102.500.3 NMAC, 7/1/2024]

8.102.500.4 DURATION: Permanent.
[8.102.500.4 NMAC - Rp 8.102.500.4 NMAC, 7/1/2024]

8.102.500.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.500.5 NMAC - Rp 8.102.500.5 NMAC, 7/1/2024]

8.102.500.6 OBJECTIVE:
A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.
B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.
[8.102.500.6 NMAC - Rp 8.102.500.6 NMAC, 7/1/2024]

8.102.500.7 DEFINITIONS: [**RESERVED**]
[8.102.500.7 NMAC - Repealed, 8.102.500.7 NMAC, 7/1/2024]

8.102.500.8 GENERAL REQUIREMENTS:
A. Need determination process: Eligibility for NMW, state funded qualified non-citizens, and EWP cash assistance based on need

requires a finding that:

(1) the benefit group's countable gross monthly income does not exceed the gross income limit for the size of the benefit group;

(2) the benefit group's countable net income after all allowable deductions does not equal or exceed the standard of need for the size of the benefit group;

(3) the countable resources owned by and available to the benefit group do not exceed the $1,500 liquid and $2,000 non-liquid resource limits;

(4) the benefit group is eligible for a cash assistance payment after subtracting from the standard of need the benefit group's countable income, and any payment sanctions or recoupments.

B. Gross income limits: The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a) one person $1,033

(b) two persons $1,397

(c) three persons $1,761

(d) four persons $2,125

(e) five persons $2,490

(f) six persons $2,853

(g) seven persons $3,217

(h) eight persons $3,582

(i) add $365 for each additional person.

C. Eligibility for support services only: Subject to the availability of state and federal funds, a benefit group that is not receiving cash assistance but has countable gross income that is less than one hundred percent of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services. The gross income guidelines for the size of the benefit group are as follows:

(1) one person $1,215

(2) two persons $1,644

(3) three persons $2,072

(4) four persons $2,500

(5) five persons $2,929

(6) six persons $3,357

(7) seven persons $3,785

(8) eight persons $4,214

(9) add $429 for each additional person.

D. Standard of need:

(1) The standard of need is based on the number of participants included in the benefit group and allows for a financial standard and basic needs.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and the participant's share of benefit group supplies.

(3) The financial standard includes approximately $112 per month for each participant in the benefit group.

(4) The standard of need for the NMW, state funded qualified non-citizens, and EWP cash assistance benefit group is:

(a) one person $327

(b) two persons $439

(c) three persons $550

(d) four persons $663

(e) five persons $775

(f) six persons $887

(g) seven persons $999

(h) eight persons $1,134

(i) add $112 for each additional person.

E. Special needs:

(1) Special clothing allowance: A special clothing allowance may be issued to assist in preparing a child for school, subject to the availability of state or federal funds and a specific allocation of the available funds for this allowance.

(a) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age 19 by the end of August.

(b) The clothing allowance shall be allowed for each school-age child who is included in the NMW, TBP, state funded qualified non-citizens, or EWP cash assistance benefit group, subject to the availability of state or federal funds.

(c) The clothing allowance is not allowed in determining eligibility for NMW, TBP, state funded qualified non-citizens, EWP cash assistance, or wage subsidy.

(2) Layette: A one-time layette allowance of $25 is allowed upon the birth of a child who is included in the benefit group. The allowance shall be authorized by no later than the end of the month following the month in which the child is born.

(3) Special circumstance: Dependent upon the availability of funds and in accordance with the federal act, the HCA secretary, may establish a separate, non-recurring, cash assistance program that may waive certain New Mexico Works Act requirements due to a specific situation. This cash assistance program shall not exceed a four month time period, and is not intended to meet recurrent or ongoing needs.

F. Non-inclusion of legal guardian in benefit group:

Based on the availability of state and federal funds, the HCA may limit the eligibility of a benefit group due to the fact that a legal guardian is not included in the benefit group.
[8.102.500.8 NMAC - Rp 8.102.500.8 NMAC, 7/1/2024]

8.102.500.9 PROSPECTIVE BUDGETING:

A. Eligibility for cash assistance programs shall be determined prospectively. The benefit group must meet all eligibility criteria in the month following the month of disposition. Eligibility and amount of payment shall be determined prospectively for each month in the certification period.

B. Simplified reporting: A benefit group subject to simplified reporting shall be subject to income methodology as specified in Subsection E of 8.102.120.11 NMAC.

C. Changes in benefit group composition: A person added to the benefit group shall have eligibility determined prospectively beginning in the month following the month the report is made.

D. Anticipating income: In determining the benefit group's eligibility and benefit amount, the income already received and any income the benefit group expects to receive during the certification period shall be used.

(1) Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

(2) Actual income shall be calculated by using the income already received and any other income that can reasonably be anticipated in the calendar month.

(3) If the amount of income or date of receipt is uncertain, the portion of the income that is uncertain shall not be counted.

(4) In cases where the receipt of income is reasonably certain but the amount may fluctuate, the income shall be averaged.

(5) Averaging is used to determine a monthly calculation when there is fluctuating income within the weekly, biweekly, or monthly pay period and to achieve a uniform amount for projecting.

E. Income received less frequently than monthly: The amount of monthly gross income that is received less frequently than monthly is determined by dividing the total income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not actually have a contract.

F. Contract income: A benefit group that derives its annual income in a period of less than one year shall have that income averaged over a 12 month period, provided that the income is not received on an hourly or piecework basis.

G. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the benefit group has chosen not to average income;

(2) income is from a source terminated in the month of application;

(3) employment began in the application month and the income represents only a partial month;

(4) income is received more frequently than weekly.

H. Income projection: Earned income shall be anticipated as described below.

(1) Earned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and the caseworker are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and the caseworker determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and the caseworker are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

I. Unearned income:

(1) Unearned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and the caseworker are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and the caseworker determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and the caseworker are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

J. Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly

amount as follows:

(1) income received on a weekly basis is averaged and multiplied by four;

(2) income received on a biweekly basis is averaged and multiplied by two;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

[8.102.500.9 NMAC - Rp 8.102.500.9 NMAC, 7/1/2024]

8.102.500.10 DIVERSION PAYMENTS TO A NMW BENEFIT GROUP:

A. Purpose: The diversion payment is a one-time cash assistance payment, that is intended to assist the benefit group alleviate a specific short-term need: to accept a bona fide offer of employment, retain employment, remedy an emergency situation or an unexpected short-term need.

B. Eligibility criteria:

(1) Applicant: Eligibility for a diversion payment shall be limited to an applicant making an initial application for cash assistance. Initial application shall not include a NMW cash assistance case which is within a six-month mandatory closure because of a third sanction. For the purposes of diversion payments, an initial applicant is one who has never received cash assistance, or one whose cash assistance case has been closed for one or more calendar months.

(a) An applicant for NMW cash assistance who meets all NMW eligibility criteria may volunteer to accept a NMW diversion payment in lieu of monthly cash assistance payments if there is no need for long-term cash assistance to meet basic needs.

(b) The caseworker shall explain the diversion program is not a supplement to other assistance but is in place of it and screen the applicant for eligibility for a diversion payment.

(c) Final approval for all diversion payments shall be made by the county director and documentation submitted to income support division central office.

(2) NMW eligibility is established:

(a) The applicant must be otherwise eligible for NMW cash assistance, except that the applicant demonstrates that monthly cash assistance to meet basic needs is not required by the benefit group because there is a means of on-going financial support, and the applicant chooses to accept a diversion payment in lieu of cash assistance to meet ongoing needs.

(b) An applicant who cannot demonstrate that monthly cash assistance to meet basic needs is not needed shall not be eligible for a diversion payment.

(3) Specific need: The applicant must make an informed choice whether cash assistance is needed to meet a specific short term need. The applicant may demonstrate a need for a specific item or type of assistance which will allow the applicant to keep a job or accept a bona fide offer of employment, remedy and emergency situation or alleviate a short term need. Such assistance may include, cash, support services, housing, transportation, car repairs, and uniforms.

(4) Eligibility for support services: A recipient of a diversion payment shall remain eligible for support services such as child care and transportation until the end of the 12-month lock-out period, until closure of the case is requested or the participant moves out of state. A referral to the NMW work program service provider and to CYFD shall be made after the applicant signs the agreement to accept a diversion payment and payment is authorized.

(5) Verification and documentation:

(a) The applicant shall be required to provide verification of the specific item or type of assistance which will allow the applicant to meet the basic short-term need.

(b) Documentation shall be required to establish that a diversion payment may be authorized in lieu of cash assistance to meet ongoing needs. An agreement signed by the applicant shall include a description of a diversion payment, terms and conditions, lifetime limitations, availability of work program services, reason for accepting a diversion payment, any prior assistance received in or out of the state.

C. Amounts: Diversion assistance is a one time, lump sum payment. The amount of the diversion payment is as follows:

(1) one to three benefit group members: may be entitled to an amount of up to $1,500 non-recurring payment; or

(2) four or more benefit group members: may be entitled to an amount of up to $2,500 non-recurring payment.

D. Countable assistance: The effects a diversion payment on other categories of assistance is as follows:

(1) the receipt of a diversion payment shall be excluded from income considerations in the medicaid program; and

(2) categorical eligibility is extended to the food stamp benefit group for the lockout period, unless the benefit group requests closure or moves out of New Mexico; and

(3) an applicant who accepts a diversion payment shall be eligible for TANF funded child care assistance for the lockout period, unless the benefit group requests closure or moves out of New Mexico.

E. Limitations and conditions: An applicant may receive a diversion payment a maximum of two times during a participant's 60-month term limit.

(1) Receipt of a diversion payment does not count toward the NMW 60-month term limit for any adult included in the

benefit group, unless the benefit group also receives monthly NMW cash assistance during the period covered by the diversion payment.

(2) The acceptance of a diversion payment does not reduce the number of months in a participant's 60-month lifetime limit; however, a diversion payment can only be authorized a maximum of two times during the 60-month lifetime limit. The 60-month lifetime limit began on July 1, 1997, for any adult or minor head of the benefit group, or spouse of the minor, who received TANF since July 1997.

(3) A participant who has reached the 60-month lifetime limit is not eligible for a diversion payment. A participant who has never received a month of TANF is eligible for a diversion payment.

(4) Cash assistance lockout period:

(a) Acceptance of a diversion payment: An applicant who accepts a diversion payment shall be prohibited from participating in the NMW cash assistance program for a period of 12 months beginning in the month the diversion payment is authorized. A written agreement that defines the terms and expectations of the diversion grant; documents the reason why cash assistance to meet basic needs is not required; identifies the need for a specific type of short-term assistance; and describes the support services available to diversion participants must be signed by the participant.

(b) Receipt of a diversion payment from another state: An applicant who has accepted a diversion payment in any other state shall be prohibited from receiving NMW cash assistance or a diversion payment in New Mexico for a period of 12 months, beginning in the month the diversion payment in the other state was authorized, or for the length of the lockout period in the other state, whichever is shorter.

(5) A participant of a diversion payment is not required to comply with work program or child support enforcement requirements.

F. Re-application: A participant may apply for cash assistance during the lockout period based on the following criteria.

(1) Applying during lock-out period: An applicant who determines an inability to adhere to the terms and conditions for receipt of a diversion payment may apply for cash assistance to meet ongoing basic needs.

(a) An applicant is ineligible for cash assistance payment regardless of good cause within the first four months of receiving a diversion payment.

(b) An applicant is eligible for cash assistance payment if good cause is met at least five months after receipt of diversion payment.

(2) Good cause: Good cause must apply in order for an applicant to re-apply for cash assistance during the lockout period. Good cause can only be considered for applicants applying at least five months after initial receipt of a diversion payment. Good cause is not considered to exist for the first four months from initial receipt of a diversion payment. Good cause must be approved by the HCA and may include, loss of employment, but not a voluntary quit or dismissal due to poor job performance or failure to meet a condition of employment; or use of an illegal substance or other drug; catastrophic illness or accident of a family member which requires an employed participant to leave employment; a victim of domestic violence; or another situation or emergency that renders an employed family member unable to care for the basic needs of the family.

G. Claims:

(1) A benefit group that receives monthly cash assistance within the 12-month lock out period shall not be subject to an overpayment if the household meets good cause.

(2) A benefit group may be subject to an overpayment if the diversion payment was issued in error and subject to recoupment as specified in 8.102.640 NMAC.

[8.102.500.10 NMAC - Rp 8.102.500.10 NMAC, 7/1/2024]

History of 8.102.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD FA 420, Standard of Need, 2/10/1988.
ISD FA 440, Determination of Eligibility and Grant, 2/10/1988.
ISD FA 440, Prospective Eligibility and Budgeting, 4/30/1992.
ISD FA 460, Special Payments, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.500 NMAC Eligibility Policy - General Information, - Repealed, 07/01/2001.
8.102.500 NMAC - Eligibility Policy - General Information (filed 6/18/2001) Repealed, effective 7/1/2024.

Other: 8.102.500 NMAC - Eligibility Policy - General Information (filed 6/18/2001) Replaced by 8.102.500 NMAC - Eligibility Policy - General Information, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 501 TRANSITION BONUS PROGRAM

8.102.501.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.501.1 NMAC - Rp 8.102.501.1 NMAC, 7/1/2024]

8.102.501.2 SCOPE: The rule

applies to the general public.
[8.102.501.2 NMAC - Rp 8.102.501.2 NMAC, 7/1/2024]

8.102.501.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998 (NMW), the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its financial assistance programs.

E. Effective July 1, 2008, in accordance with the requirements of the New Mexico Works Act, the HCA is creating the Transition Bonus Program (TBP) as one of its financial assistance programs.

F. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at title 7, code of federal regulations.

G. 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.
[8.102.501.3 NMAC - Rp 8.102.501.3 NMAC, 7/1/2024]

8.102.501.4 DURATION: Permanent.
[8.102.501.4 NMAC - Rp 8.102.501.4 NMAC, 7/1/2024]

8.102.501.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.501.5 NMAC - Rp 8.102.501.5 NMAC, 7/1/2024]

8.102.501.6 OBJECTIVE:

A. The purpose NMW program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment, child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participant benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

C. The objective of the TBP is to provide for a limited duration and a fixed monthly cash assistance bonus incentive to encourage NMW families to leave NMW cash assistance and participate in the TBP by maintaining a certain number of hours in paid employment and leave the TBP due to increased earnings.
[8.102.501.6 NMAC - Rp 8.102.501.6 NMAC, 7/1/2024]

8.102.501.7 DEFINITIONS: Limited state or federal funds as discussed in this part means that available funds would warrant a fixed benefit amount of less than $200 per month.
[8.102.501.7 NMAC - Rp 8.102.501.7 NMAC, 7/1/2024]

8.102.501.8 TRANSITION BONUS PROGRAM:

A. Purpose: The TBP provides a limited duration and fixed month cash assistance bonus incentive to encourage NMW families to leave NMW cash assistance, participate in the TBP by maintaining a certain number of hours in paid employment and leave the TBP due to increased earnings. This program also provides supportive services on an ongoing basis, provided that the participant is eligible to receive the services during the months provided.

B. Method of payment: TBP payments are paid by issuing funds into an electronic benefits transfer (EBT) account accessible to the participant. In some circumstances benefits may be issued by warrant.

C. Fixed benefit amount: A non-prorated, benefit amount of $200 will be given to all TBP participants under one-hundred fifty-percent of federal poverty guidelines. The benefit can be reduced to recoup an existing cash assistance overpayment in accordance with 8.100.640 NMAC. The benefit will be countable for the benefit group's eligibility for SNAP and Medicaid benefits unless otherwise excluded.

D. Lifetime limits:

(1) The TBP benefit shall not be provided to an adult, minor head of household or the spouse of a minor head of household for more than 18 months during the individual's lifetime. A benefit group as defined at 8.102.400 NMAC shall be ineligible if the benefit group contains at least one adult, minor head of household or spouse of the minor head of household who has received 18 or more months of the TBP benefit.

(2) Any month in which an adult, a minor head of household, or the spouse of a minor head of household, has

received full or partial TBP benefit shall be considered a month of receipt and shall be counted towards the 18 month lifetime limit for any benefit group in which that individual is a member.

(3) Participants who receive state funded TBP shall not have any month received count towards their 60-month lifetime limit for NMW eligibility.

(4) Participants who receive federally funded TBP shall have each month received count toward the 60-month lifetime limit for NMW eligibility.

(5) When state and federal funds are appropriated, the lifetime limit will be applied as follows:

(a) any participant who has received 31 months or more of TANF will receive state funds;

(b) any participant who has received 30 months or less of TANF will receive federal funds.

E. Initial eligibility:

(1) The TBP program shall be subject to all federal and state NMW cash assistance application, eligibility, certification and reporting requirements, except where specified within the TBP regulations. Resources of the budget group are excluded in determining eligibility for the TBP.

(2) Application requirements: Active NMW benefit groups that meet the qualifications and eligibility requirements for the TBP shall be eligible without an application. An application will be required if the NMW case is closed.

(3) The TBP shall be available only to a benefit group that meets all of the following criteria:

(a) does not simultaneously participate in the NMW program;

(b) has left the NMW cash assistance program;

(c) meets all TBP requirements and voluntarily chooses to participate in the program;

(d) is currently engaged in paid unsubsidized or subsidized employment, except for subsidized employment funded with TANF, for a minimum of 30 hours per week, and earnings paid at federal minimum wage, or if self-employed, working a minimum of 30 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours;

(e) has gross income that does not exceed one-hundred fifty percent of federal poverty guidelines;

(f) has received NMW funded cash assistance for at least three months and one of the last three months; and

(g) does not include an adult, minor head of household or spouse of the minor head of household that participated in the TBP for 18 months in their lifetime or 60 months of TANF.

(4) Eligibility for the TBP shall be prospective for a six month period up to a lifetime limit of 18 months.

F. In accordance with Subsection B of 8.102.500.8 NMAC, income eligibility limits for the TBP will be revised and adjusted each year in October.

[8.102.501.8 NMAC - Rp 8.102.501.8 NMAC, 7/1/2024]

8.102.501.9 CONTINUED ELIGIBILITY:

A. Six month reporting requirement: All benefit groups participating in the TBP shall be assigned to a six month reporting requirement. A benefit group assigned to a six month reporting shall be required to file a six month report no later than the 10 day of the sixth month or in conjunction with the interim report or SNAP recertification, whichever is appropriate. The benefit group must include the following information along with verification:

(1) any change in benefit group composition, whether a member has moved in or out of the home along with the date, the change took place;

(2) the amount of money received from employment by each benefit group member;

(3) the amount of unearned income received by each benefit group member;

(4) verification for residence, only if, there has been a change in residence since the last certification;

(5) changes in child support receipt; and

(6) changes in alien status for a benefit group member.

B. Continued eligibility at the six month reporting: For continued TBP eligibility, the benefit group must meet all of the following criteria:

(1) engaged in paid unsubsidized employment for at least 30 hours per week, averaged over a month;

(2) have earnings from paid unsubsidized employment that do not exceed one-hundred fifty percent of the federal poverty guidelines; and

(3) have not reached the benefit group's 18 month TBP lifetime limit or 60-month lifetime limit as an adult, minor head of household or spouse of a minor head of household.

C. Action on changes reported between reporting periods for benefit groups assigned to six month reporting:

(1) The HCA shall not act on reported changes between reporting periods that would result in a decrease in benefits with the following exceptions:

(a) a benefit group reports income in excess of one-hundred fifty percent of federal poverty guidelines for size of the benefit group;

(b) a benefit group report loss of paid unsubsidized employment;

(c) a benefit group reports, or the HCA receives documented evidence that

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

(d) a benefit group requests closure;

(e) the HCA receives documented evidence that the head the of benefit group has died; or

(f) at the time of a mass change.

(2) A newborn shall be added to the benefit group effective the month following the month the report is received, if the addition is reported to the agency by the benefit group or by the hospital for medicaid purposes.

D. Notice: An eligible benefit group that qualifies and is eligible for the bonus shall be issued notice in accordance with policy at 8.102.110.13 NMAC and for the following circumstances:

(1) Approval: An approval notice shall be issued at the time the benefit group is determined eligible. The approval notice shall identify the amount of approval and recertification date.

(2) Benefit change: A benefit group shall be issued a notice at the time the benefit group is increased or decreased. The amount of benefit is subject to change due to the availability of state or federal funds.

(3) Ineligibility: A benefit group shall be issued a notice when the benefit group no longer qualifies or is not eligible for the TBP due to a reportable change or at time of interim reporting.

[8.102.501.9 NMAC - Rp 8.102.501.9 NMAC, 7/1/2024]

8.102.501.10 BENEFIT ISSUANCE AND DELIVERY:

A. Benefit issuance: The TBP benefits are issued and placed into a benefit group's electronic benefit transfer (EBT) cash assistance account as defined in 8.102.610.8 NMAC.

B. Supportive services: Participants of the TBP shall be eligible to receive NMW case management and supportive services in accordance with 8.102.620.14, 8.102.620.15, and 8.102.620.16 NMAC.

C. Special allowances: A special clothing allowance for school age children and layette payment shall be issued pursuant to 8.102.500.8 NMAC.

D. Expungement: The TBP benefit shall be subject to expungement in accordance with 8.102.610.9 NMAC.

E. Issuance and replacement of EBT card: To access and use the TBP benefit, the benefit group may use the same EBT card issued for the cash assistance benefits.

F. Approval notification: Upon approval of the transition bonus program benefit, the household shall be notified of the new benefit amount and the notice shall be mailed to the applicant per 8.102.110.13 NMAC.

[8.102.501.10 NMAC - Rp 8.102.501.10 NMAC, 7/1/2024]

8.102.501.11 NMW PARTICIPATION REQUIREMENTS: A TBP recipient will be encouraged to participate in work program activities and shall be expected to attend and complete all required activities, such as the assessment, individual responsibility plan (IRP), work participation agreement (WPA) and monthly participation requirements in accordance with 8.102.460 NMAC if not otherwise meeting. Participation requirements apply to each benefit group member whether the benefit group is considered to be a two-parent or single-parent benefit group. No TBP participant shall be sanctioned for NMW non-cooperation.

A. Work Participation Agreement activity will include:

(1) 30 hours a week engaged in paid employment at federal minimum wage, or if self-employed, working a minimum of 30 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours.

(2) Career development that will lead towards meaningful employment.

B. Failure to comply with Subsection A of 8.102.501.11 NMAC will result in closure of TBP and return to regular TANF.

C. Regain eligibility: A participant can regain eligibility by showing they are complying with the TBP NMW participation requirements.

[8.102.501.11 NMAC - Rp 8.102.501.11 NMAC, 7/1/2024]

8.102.501.12 SUSPENSION OF PROGRAM: The TBP payment for all benefit groups may be denied for a designated time period based on limited state or federal funds. During program suspension disposition of applications shall be made pursuant to 8.106.110.16 NMAC.

A. Application disposition: All applications for TBP shall be denied under this provision without consideration of eligibility.

(1) Interview: TBP applications denied on the basis of suspension shall not require an interview to meet the requirements specific to TBP, other categories of assistance requested by the applicant may require an interview to determine eligibility.

(2) Payment of assistance: There shall be no payment to the TBP recipient during the designated suspension period and any right to the payment is lost. Retroactive payments for pending applicants shall be authorized for months prior to a designated suspension period.

B. Notice to recipient and applicant: No later than 60 days prior to the effective change the HCA shall provide transition bonus recipients appropriate notice regarding suspension or restoration of the grant based on the availability of state or federal funds. The notice shall include the citation to the state statute and regulation and fair hearing rights.

C. Public notice: The HCA shall issue a public notice 60 days prior to the changes made based on the availability of state or federal

funds. Public notice shall include effective date of change and right to fair hearing consistent with mass change requirements at 8.100.180.15 NMAC.

D. Claims: Claims for overpayments shall be established in accordance with regulations outlined at 8.100.640.11 NMAC.

E. Expungement: Cash assistance benefits will be expunged in accordance with regulations outlined in Subsection B of 8.102.610.9 NMAC.
[8.102.501.1 NMAC - Rp 8.102.501.1 NMAC, 7/1/2024]

HISTORY OF 8.102.501 NMAC: [**RESERVED**]

History of Repealed Material:
8.102.501 NMAC - Transition Bonus Program (filed 6/2/2008) Repealed, effective 7/1/2024.
Other: 8.102.501 NMAC - Transition Bonus Program (filed 6/2/2008) Replaced by 8.102.501 NMAC - Transition Bonus Program, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 510 ELIGIBILITY POLICY - RESOURCES/PROPERTY

8.102.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.510.1 NMAC - Rp 8.102.510.1 NMAC, 7/1/2024]

8.102.510.2 SCOPE: The rule applies to the general public.
[8.102.510.2 NMAC - Rp 8.102.510.2 NMAC, 7/1/2024]

8.102.510.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. 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.
[8.102.510.3 NMAC - Rp 8.102.510.3 NMAC, 7/1/2024]

8.102.510.4 DURATION: Permanent.
[8.102.510.4 NMAC - Rp 8.102.510.4 NMAC, 7/1/2024]

8.102.510.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.510.5 NMAC - Rp 8.102.510.5 NMAC, 7/1/2024]

8.102.510.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.
[8.102.510.6 NMAC - Rp 8.102.510.6 NMAC, 7/1/2024]

8.102.510.7 DEFINITIONS: [**RESERVED**]
[8.102.510.7 NMAC - Repealed, 8.102.510.7 NMAC, 7/1/2024]

8.102.510.8 RESOURCE STANDARDS: To be eligible on the condition of need, the value of all countable personal and real property, belonging to, or considered as belonging to or considered available to the benefit group shall not exceed the liquid and non-liquid resource limits. Property in excess of the liquid and non-liquid resource limits makes the benefit group ineligible unless the nature of the property or an express condition of its ownership prohibits its transfer. Resources are evaluated based upon their equity value.

A. Liquid resources: Liquid resources are those properties in the form of cash or other financial instruments which are easily convertible to cash and include but are not limited to: savings accounts, checking accounts, stocks, bonds, mutual fund shares, promissory notes, mortgages, cash value of insurance policies, and similar properties. The

value of countable liquid resources may not exceed $1,500.

B. Non-liquid resources: Non-liquid resources are all resources that cannot be easily converted to cash and include, but are not limited to: both real and personal property. The value of countable non-liquid resources may not exceed $2,000.

[8.102.510.8 NMAC - Rp 8.102.510.8 NMAC, 7/1/2024]

8.102.510.9 COUNTABLE RESOURCES:

A. Real property non-liquid:

(1) Real property means land and the structures and improvements affixed to it.

(2) The value of real property owned by or considered available to the benefit group, except as exempted in Subsection A of 8.102.510.10 NMAC, shall be considered in determining whether non-liquid resources exceed $2,000.

(3) Grazing permits are classified as real property.

B. Personal property (liquid or non-liquid): The value of personal property other than that exempted in Subsection B of 8.102.510.10 NMAC, belonging to, considered as belonging to, or available to the benefit group, is considered in determining whether the value of property exceeds the resource limits. Personal property is all property other than real property, and includes such possessions as bank accounts, cash (other than the current month's income), motor vehicles, livestock, tools, equipment, and rights to receive money, such as stocks, bonds, contract rights and insurance policies, etc. The types of personal property that must be counted in determining whether the benefit group's resources exceed the resource limits include, but are not limited to the following.

(1) Life insurance:

(a) Life insurance policies owned by a member of the benefit group shall be considered as a resource that may be converted into cash. The cash value of the life insurance policy shall be counted toward the liquid resource limit.

(b) Information about lapsed insurance shall be obtained since many lapsed policies have a cash value.

(2) Cash, bank accounts and other readily negotiable assets: "Other readily negotiable assets" include stocks, bonds, negotiable notes, purchase contracts and other similar assets. For purposes of cash assistance eligibility, the value of such assets is their current market value. These shall be counted toward the liquid resource limit.

(3) Motor vehicles, equipment, and tools:

(a) The equity value of all motor vehicles, equipment and tools is subject to consideration.

(b) The value of motor vehicles, equipment and tools, except as set forth in Paragraph (1) of Subsection B of 8.102.510.10 NMAC below, is subject to the non-liquid resource test.

(4) Asset conversion: Money received from one-time only or sporadic sales of real or personal property such as crops, rugs, jewelry, royalties etc. shall be considered an asset, rather than income, provided that the property is not sold or transferred in connection with a business or self-employment activity. Actual verified expenses associated with the purchase, sale or production of such items shall be deducted from payments received from the sale to arrive at "net asset". Assets converted into money are subject to the $1,500 liquid assets limitation, regardless of whether they were fully or partially exempt prior to conversion.

(5) Lump sum payments: Payments of a one-time nature, such as retroactive monthly payments, payments in the nature of a windfall, personal injury and worker's compensation awards, gambling winnings, etc, shall be considered to be a resource in the month received. Countable value is considered as a liquid resource. Resource eligibility is determined on the first moment of the first day of the month. Changes during the month do not affect the resource determination for that month; what is left at the first moment of the first day of the month following its receipt will be the countable amount.

[8.102.510.9 NMAC - Rp 8.102.510.9 NMAC, 7/1/2024]

8.102.510.10 RESOURCE EXCLUSIONS:

A. Real property:

(1) The home: The value of the benefit group's home and certain other property, as defined below, is not considered in determining eligibility. The "home" is the dwelling place occupied by the benefit group. The home is considered to be occupied by the benefit group during a temporary absence from the home when there is a definite plan to return to the home and no one else is occupying it. "Home" includes, in addition to the residence building and the land upon which it is constructed, the following:

(a) a reasonable amount of land within reasonable proximity to the residence building if that land is currently used by and useful to the client;

(b) outbuildings within reasonable proximity to the residence building, such as barn, garage and well, if the well is a principal source of water;

(c) buildings used for rental purposes if located on land contiguous to the land upon which the residence building is constructed and if these buildings cannot be divided from the residence land and sold separately;

(d) grazing permits currently being used to graze livestock owned by the client;

(e) furniture, equipment and household goods necessary for the operation and maintenance of the home.

(2) Other real property - burial plots: One burial

plot for each person included in the benefit group; a burial plot shall consist of the space needed to bury members of the immediate family.

B. Exempt personal property: The value of the following items of personal property shall not be considered in determining eligibility for financial assistance.

(1) Vehicles:

(a) Transportation to or from work/daily living: Vehicles used for transportation of benefit group members to or from work or work activities, for daily living activities, or for transportation of goods or services shall not be considered in the determination of resources attributed to the benefit group.

(b) Specially equipped vehicles: A vehicle that is specially equipped for those with physical impairments shall not be considered in the determination of resources attributed to the benefit group.

(2) Exempt income: Any income which is exempt under income provisions is also exempt from consideration as a resource. To maintain its exempt status, exempt income which is accumulated must be kept separately from non-exempt savings.

(3) Funeral agreements: The equity value of funeral agreements owned by a benefit group member. Funeral agreements include any arrangement under which prepaid funeral services are provided or cash benefits which are intended to pay for funeral services are paid upon the death of the person. Included as such agreements are contracts with funeral homes, life or burial insurance, or trust or escrow accounts in financial institutions or banks, provided that the trust or escrow accounts contain provisions making the funds payable only upon the death of a named individual. There is no limit on the amount which can be disregarded.

(4) Contingent and unliquidated claims: A "contingent and unliquidated claim" is an as yet undetermined right of the client to receive, at some future time, a resource such as an interest in an estate not probated or damages or compensation resulting from an accident or injury. Such a claim is not considered a resource to meet requirements if the benefit group member can demonstrate that the client has consulted an attorney, or that under the circumstances, it is reasonable not to have consulted an attorney, and that the benefit group member is making every reasonable effort to prosecute the benefit group member's claim or to proceed with the probate. If the benefit group member can demonstrate that the client's share in an estate not probated would be less than the expense of the proceedings to probate the estate, the value is not considered a resource.

(5) Work-related equipment exclusion: Work-related equipment, such as the tools of a trades person or the machinery of a farmer, which are essential to the employment or self-employment of a benefit group member, are excluded, in an amount not to exceed $1,000 per individual, and remain excludable, if the trades person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self-employment.

(6) Livestock: The value of livestock is an excluded non-liquid resource.

C. Individual development account (IDA): As defined in the Individual Development Account Act 58-30 NMSA, 1978, funds in an IDA are exempt from consideration as resources in determining benefit group eligibility are subject to certain requirements. To be disregarded, the IDA must be designated for a qualified use and meet all requirements as follows.

(1) IDA requirements:

(a) the benefit group member must establish the IDA for one of the purposes listed in Paragraph (2) of this subsection;

(b) in order for such accounts to be excludable, the IDA must be a trust created or organized in the United States, with trust language restricting use of account funds to the qualified uses as designated in this section; and

(c) the IDA must be funded exclusively with income earned by a benefit group member or by contributions made by a non-benefit group member;

(d) funds withdrawn from the account and used for any purpose other than those specified under this section, will cause the account to lose its status as an excluded resource, starting with the month in which the funds are so used; the amounts withdrawn also constitute an overpayment of assistance, and must be reported and shall be recouped.

(2) IDA qualified uses: Allowable uses of the money withdrawn from an IDA are listed in Subparagraph (a) thru (f) of this subsection.

(a) Post-secondary education expenses: In order to be considered used for the qualified purpose, the post-secondary education funds must be paid from an IDA directly to an eligible education institution, as set forth in this section. For purposes of this regulation, post-secondary education expenses include:

(i) tuition and fees required for the enrollment or attendance of a student at an eligible education institution; an eligible institution is an institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965 (20 USC 1088(a)(1) or 1141(a)); an area vocational education school (as defined in section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2471(4)) which is in any state; or

(ii) books, fees, supplies, and equipment required for courses of instruction at an eligible educational institution.

(b) Business capitalization: In order to be considered used for the qualified purpose, for business capitalization, the funds have to be paid directly

from the IDA to a business capitalization account established in a federally insured financial institution that is restricted to use solely for qualified business capitalization expenses. A qualified business means any business that does not contravene any law or public policy. Qualified business capitalization expenses include capital, plant, equipment, working capital, and inventory expenses. To be a qualified business, there must be a business-plan which:

(i) is approved by a financial institution, or by a nonprofit loan fund having demonstrated fiduciary integrity;

(ii) includes a description of services or goods to be sold, a marketing plan, and projected financial statements; and

(iii) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(c) First-time home purchase by a qualified buyer: The purpose of the IDA is to assist a qualified first-time home buyer to accumulate part of the cash necessary to initiate purchase of the individual's first home.

(i) Only IDA's established by qualified first-time home buyers shall be disregarded. A qualified first-time home buyer is one who has never had an ownership interest in a principal residence.

(ii) The IDA may be used only for the purchase of a qualified principal residence. A qualified principal residence is one which qualifies as the principal home under Subsection 1034 the federal internal revenue service's code, and the costs for which do not exceed one hundred percent of the average area purchase price applicable to such residence, determined in accordance with Paragraphs (2) and (3) of Subsection 143(e) of the internal revenue service's code.

(d) Home improvements: Costs of major home improvements or repairs on the home of the account owner.

(e) Death of account owner: The amount deposited by the deceased account owner held in an IDA shall be distributed directly to the account owner's spouse. If the spouse is deceased or there is no spouse the amount shall be distributed to a dependent or other named beneficiary of the deceased. The account and matching funds designated for that account from a reserve account may be transferred and maintained in the name of the surviving spouse, dependent or beneficiary.

(f) Vehicle acquisition: Acquisition of a vehicle necessary to obtain or maintain employment by an account owner or the spouse of an account owner.

D. Federally excluded resources: Certain resources are excluded pursuant to federal law. For a listing of federally excluded resources see 8.139.527 NMAC.
[8.102.510.10 NMAC - Rp 8.102.510.10 NMAC, 7/1/2024]

8.102.510.11 RESOURCE AVAILABILITY:

A. Availability: Resources that are actually available or which are considered to be available are considered in determining eligibility for assistance. For purposes of cash assistance eligibility, the countable resources of all benefit group members shall be considered to be available to the benefit group. The resource determination shall be made based upon the status of resources on the first moment of the first day of each month. Subsequent changes shall not effect the determination of eligibility or ineligibility until the first moment of the first day of the following month.

B. Potentially available resources: The benefit group is required to take all appropriate steps to make available to itself any property resources to which the group may be entitled but whose value is not currently available, which includes, but is not limited to, an inheritance, where the estate has not yet gone through probate. The fact that specific property is not readily marketable on the client's terms is not a condition prohibiting transfer. The current value of property, which must be partitioned in order to be accessible, is not considered available if the net value (after estimated costs of partition and other closing costs) is less than the resource limit. If the amount likely to be derived from the applicant's or recipient's share of the property exceeds the resource limit, the applicant or recipient will be required to initiate attempts to obtain the recipient's share of the estate.

C. SSI recipients and other non-members: The property of individuals receiving SSI or of other non-members shall not be considered available, regardless of relationship to benefit group members, except as indicated in E. below.

D. Non-citizen sponsor: The gross income and resources belonging to an individual who is the sponsor of a non-citizen included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income and resources of the non-citizen sponsor, and spouse, shall be counted until the sponsored non-citizen achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

E. Deeming resources: A liquid resource owned by a parent of a minor parent living in the home, shall be deemed on a pro rata basis, unless the parent of the minor parent receives SSI.

F. Joint property:

(1) Joint resources: Resources owned jointly by separate benefit groups shall be considered available in their entirety to each benefit group, unless it can be demonstrated by an applicant or recipient that such resources are inaccessible to it. The benefit group

must verify that:

(a) it does not have the use of the resource;

(b) it did not make the purchase or down payment;

(c) it does not make the continuing loan payments; and

(d) the title is transferred to or retained by the other benefit group;

(e) if a benefit group can demonstrate that is has access to only a part of the resource, the value of that part is counted toward the benefit group's resource level; a resource will be considered totally inaccessible, if it cannot be practically subdivided and the benefit group's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible non-citizens or disqualified individuals residing with a benefit group are considered benefit group members.

(2) Joint bank accounts: If signatories to a joint bank account are separate benefit groups, the funds in the account are considered available to each benefit group to the extent that it has contributed to the account. If the participation benefit group has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other benefit group intends that the participation benefit group actually owns the funds.

[8.102.510.11 NMAC - Rp 8.102.510.11 NMAC, 7/1/2024]

8.102.510.12 [RESERVED]

8.102.510.13 ELIGIBILITY DETERMINATION:

A. Determination: After determining what property is available to the benefit group and determining the value of that resource, the net value of the countable real and personal property exceeds resource limits, the benefit group shall be ineligible for assistance on the basis of need. The benefit group shall remain ineligible on the condition of need for as long as the value of the property exceeds the resource standards. The basis of need is determined by:

(1) what property is available to the benefit group;

(2) the value of all available resources;

(3) what the net value of all countable real and personal property.

B. Receipt of resources: Resources acquired by a benefit group member after approval of an assistance grant shall be evaluated for purposes of financial assistance eligibility at the time of the change. Reporting requirements as indicated in Subsection D of 8.102.630.8 NMAC apply. If ownership or availability of resources makes the benefit group ineligible, assistance is terminated effective the month following the month the notice of adverse action expires.

[8.102.510.13 NMAC - Rp 8.102.510.13 NMAC, 7/1/2024]

8.102.510.14 NON-TRANSFER OF REAL PROPERTY:

A. Requirement:

(1) For the parent or the specified relative to be included in the benefit group, a benefit group member must not have transferred real property for the purpose of becoming eligible for cash assistance within the two-year period preceding the date of application.

(2) A transfer is considered to be for the purpose of becoming eligible if:

(a) the transfer was made without a reasonable return; and

(b) the person had no reasonable plan for support at the time of the transfer other than assistance from the HCA.

B. Transfer:

(1) For the purpose of this provision, transfer includes the sale, conveyance by deed, or any other method of transferring the title to the property involved, including transfer by gift. The transfer may be for either the title to the real property or other interests or rights in the property, such as mineral or water rights.

(2) A child under the age of 18 years cannot transfer property, except through a guardian. If facts indicate the existence of a trust, inheritance or prior gifts to the child, it must be determined whether a transfer has taken place.

C. Reasonable return: A reasonable return is considered to have been received when the person who made the transfer received compensation in cash or in kind equal to the value of the property at the time of transfer. The determination as to whether a reasonable return was received is based on the person's equity interest in the property at the time of the transfer.

D. Equity less than $2,000: If the value of the person's equity, plus all other countable resources, was less than $2,000, the transfer is not considered to be for the purpose of becoming eligible.

E. Reasonable value not received:

(1) When it is determined that the property was transferred for the purpose of becoming eligible, but the client has subsequently made efforts to obtain a reasonable return, or to regain title, and is willing to continue such efforts, if indicated, eligibility on this condition exists. When the client is not willing to pursue a reasonable return, or to attempt to regain title to the property, the case shall not be eligible for six months from the month the HCA makes the determination that the transfer was made.

(2) Any proceeds received in return for property transfers shall be evaluated to determine if they affect the client's ongoing eligibility for cash assistance.

[8.102.510.14 NMAC - Rp 8.102.510.14 NMAC, 7/1/2024]

HISTORY OF 8.102.510 NMAC:

Pre-NMAC History: The material in this part was derived from that

previously filed with the State Records Center and Archives:
ISD FA 410, Resources, 2/10/1988.
ISD FA 410, Resources, 6/18/1990.
ISD FA 440, Determination of Eligibility and Grant, 2/10/1988.
ISD FA 440, Prospective Eligibility and Budgeting, 4/30/1992.
ISD FA 310, Non-Financial Eligibility Criteria, 2/9/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.510 Eligibility Policy - Resources/Property - Repealed, 07/01/2001.
8.102.510 NMAC - Eligibility Policy - Resources/Property (filed 6/18/2001) - Repealed effective 7/1/2024.

Other: 8.102.510 NMAC - Eligibility Policy - Resources/Property (filed 6/18/2001) - Replaced by 8.102.510 NMAC - Eligibility Policy - Resources/Property, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 520 ELIGIBILITY POLICY - INCOME

8.102.520.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.520.1 NMAC - Rp 8.102.520.1 NMAC, 7/1/2024]

8.102.520.2 SCOPE: The rule applies to the general public.
[8.102.520.2 NMAC - Rp 8.102.520.2 NMAC, 7/1/2024]

8.102.520.3 STATUTORY AUTHORITY:
A. 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.
B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.
C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.
D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.
E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.
F. 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.
[8.102.520.3 NMAC - Rp 8.102.520.3 NMAC, 7/1/2024]

8.102.520.4 DURATION: Permanent.
[8.102.520.4 NMAC - Rp 8.102.520.4 NMAC, 7/1/2024]

8.102.520.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.520.5 NMAC - Rp 8.102.520.5 NMAC, 7/1/2024]

8.102.520.6 OBJECTIVE:
A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.
B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.
[8.102.520.6 NMAC - Rp 8.102.520.6 NMAC, 7/1/2024]

8.102.520.7 DEFINITIONS: [**RESERVED**]
[8.102.520.7 NMAC - Rp 8.102.520.7 NMAC, 7/1/2024]

8.102.520.8 GENERAL:
A. Income eligibility: To be eligible for cash assistance based on income eligibility factors:
(1) the countable gross income available to the benefit group cannot equal or exceed the maximum gross income limit for the size of the benefit group;
(2) the net countable income available to the benefit group cannot equal or exceed the standard of need applicable to the size of the benefit group;
(3) all income exempted or deducted in the gross income test shall be exempted or deducted in the net income test;
(4) all income considered available in the net income test shall be considered in determining the amount of payment to the benefit group.
B. Gross income test (eighty-five percent test): For the benefit group to be eligible, the

countable gross income available to the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

C. Net income test: For the benefit group to be eligible, the countable net income must be less than the standard of need applicable to the size of the benefit group.

D. Eligibility for support services only: Subject to the availability of state and federal funds, a benefit group that is not receiving cash assistance but has countable gross income that is less than one hundred percent of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services.

E. Counting income during the certification period:

(1) For the purposes of cash assistance eligibility and payment determination, income is money received by or available to the benefit group in each month of the certification period.

(2) Only income which is actually received, or can reasonably be expected to be received, is counted for financial eligibility and payment calculation.

(3) The benefit group must take appropriate steps to apply for and receive income from any other source to which the group may potentially be eligible. A benefit group may be found ineligible for failing or refusing to apply for or pursue potential benefits from other sources.

(4) A benefit group member who is 62 years of age or older must apply for and take all necessary steps to receive a reduced OASDI benefit in order to comply with this eligibility criterion.

F. Income availability:

(1) The availability of income to the benefit group is determined by who must be included in the benefit group, and whether income must be deemed available to the benefit group.

(2) Income belongs to the person who gains it, either through the person's own efforts, as in the case of earnings, or as a benefit, as in the case of a beneficiary of social security administration income.

(3) Any unearned income, benefits, or payments, such as but not limited to: child support or social security benefits, for a child are considered as belonging to the benefit group in which the child is included.

(4) Non-citizen sponsors: The gross income and resources belonging to an individual who is the sponsor of a non-citizen included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income and resources of the non-citizen sponsor, and spouse, shall be counted until the sponsored non-citizen achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

G. Unavailable income: In some situations, individuals who are included in the benefit group, either an applicant or participant status, have a legal right to income but do not have access to it. Such income is not counted as available income for purposes of cash assistance eligibility and benefit calculation. A benefit group may be found ineligible for failing or refusing to immediately take all steps necessary to obtain access to the income.

H. Ineligible non-citizen: The countable income belonging to an ineligible non-citizen is deemed available to the benefit group and is prorated according to the size of the benefit group to determine the eligibility and payment amount for the benefit group.

[8.102.520.8 NMAC - Rp 8.102.520.8 NMAC, 7/1/2024]

8.102.520.9 EXEMPT INCOME: The following income sources are not considered available for the gross income test, the net income test, and the cash payment calculation:

A. medicaid;

B. food stamp benefits;

C. government-subsidized foster care, if the child for whom the payment is received is not included in the benefit group;

D. SSI;

E. government-subsidized housing or a housing payment; government includes any federal, state, local or tribal government or a private non-profit or for profit entity operating housing programs or using governmental funds to provide subsidized housing or to make housing payments;

F. income excluded by federal law (described in 8.139.527 NMAC);

G. educational payments made directly to an educational institution;

H. government-subsidized child care;

I. earned income that belongs to a child 17 years of age or younger who is not the head of household; only earned income paid directly to the child is considered as belonging to the child;

J. up to $50 child support disregard and $100 for one child and $200 for two or more children per month, child support pass-through distributed to the benefit group by the CSSD;

K. an emergency one-time only payment made by other agencies or programs;

L. reimbursements for past or future identified expenses, to the extent they do not exceed actual expenses, and do not represent a gain or benefit to the benefit group, such as expenses for job or job training related activities, travel, per diem, uniforms, transportation costs to and from the job or training site, and medical or dependent care reimbursements and any reimbursement for expenses incurred while participating in NMW work program activities; reimbursements for normal living expenses, such as

rent, mortgage, clothing or food eaten at home are not excluded;

M. utility assistance payments such as from low-income home energy assistance program (LIHEAP), low-income assistance program (LITAP), or similar assistance programs.

N. subsidized private sector employment: as outlined at Subsection B of 8.102.461.12 NMAC.

O. guaranteed basic income**:** any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

P. universal basic income: any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

[8.102.520.9 NMAC - Rp 8.102.520.9 NMAC, 7/1/2024]

8.102.520.10 EARNED INCOME DEFINITION:

A. Earned income means cash or payment in kind that is received as wages from employment, payment in lieu of wages, earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

B. Earnings include gross profit from self-employment, which requires substantial effort on a continuous basis by the participant who is receiving the income.

(1) Income from rental property is considered earnings if the participant regularly does painting, plumbing, carpentry, maintenance, cleaning, or repair work on the property; or if substantial time is spent each month in bookkeeping, collecting rent, or paying bills on the property.

(2) Income from livestock is considered earnings if the participant raises livestock for the purpose of making cash sales. Net income received from the sale of livestock shall be considered in determining amount of the cash assistance grant.

(a) The income received from this operation may be prorated on a semiannual period if it is reasonable to expect that the client will realize the same amount during the next budgetary period.

(b) Domestic pets (cats, dogs, etc.) are not considered livestock, and their value is not considered in determining resource eligibility except where they are bred and raised for sale.

C. The use of property, such as inhabiting a home or apartment, is considered as earnings if it is received in exchange for services provided to the person owning or controlling the property.

[8.102.520.10 NMAC - Rp 8.102.520.10 NMAC, 7/1/2024]

8.102.520.11 DETERMINING INCOME FOR SELF-EMPLOYED INDIVIDUALS:

A. Reporting of earnings as business or self-employment income to state or federal tax authorities is the usual indicator of business or self-employment income. Criteria for verification of business and self-employment income are set forth in Paragraph (2) of Subsection B of 8.100.130.14 NMAC.

(1) Tax returns from the previous year may be used, unless the amount of business and self-employment income reported on tax returns is no longer a good indicator of expected income.

(2) When tax forms are used to annualize and project income, the expenses reported on the tax forms shall be used, allowing for adjustments for those expenses or costs that are treated differently or not allowed under cash assistance policy.

(3) Capital gains are counted in full as income to determine self-employment income. A capital gain is defined as proceeds from the sale of capital goods or equipment.

B. Averaging business or self-employment income: Business or self-employment income is averaged over the period the income is intended to cover, even if the benefit group receives income from other sources.

(1) Benefit groups which by contract or self-employment derive their annual income in a period of time shorter than one year must have income averaged over a twelve-month period.

(2) If significant changes have occurred because of a substantial increase or decrease in business and averaged income will not accurately reflect the self-employed individuals' income, the self-employment income shall be calculated on the basis of anticipated, not prior, earnings.

(3) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year.

(4) If the self-employment enterprise has been in operation for such a short time that there is insufficient information to make a reasonable projection, the benefit group shall be required to report income at shorter intervals until there is enough information to make a longer projection of anticipated income.

(5) Seasonal income: Self-employment income that is intended to meet the benefit group's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

C. Determining monthly business or self-employment income: For the period of time over which self-employment income is averaged, the individual's monthly self-employment income is determined by adding all self-employment income, including capital gains, and excluding allowable costs of producing the self-employment income, and dividing the resulting self-employment income by the number of months over which the income will be averaged.

[8.102.520.11 NMAC - Rp 8.102.520.11 NMAC, 7/1/2024]

8.102.520.12 EARNED

INCOME DEDUCTIONS:

A. Earnings deductions: Deductions from gross earned income shall be made in determining the net countable earned income of benefit group members.

(1) Earned income deductions may not exceed the amount of a participant's gross earned income.

(2) The earned income deductions may not be used to reduce unearned income, nor may deductions that are not used by one benefit group member be allocated against the earnings of another benefit group member.

(3) An allowable deduction that is not verified at the time of certification or processing of the semiannual report shall not be allowed as a deduction. A deduction verified after certification shall be processed as a change.

(4) An allowable deduction that is verified after a semiannual report is processed shall be handled as set forth at Subsection I of 8.102.120.11 NMAC.

B. Business expenses and self-employment costs: Business expenses and self-employment costs shall be deducted from the gross earnings of a self- employed benefit group member. The income after all allowable business expenses and self-employment costs shall be counted as the gross income of the benefit group member. To be eligible for this expense a tax ID shall be required.

(1) Allowable expenses and costs: Allowable costs of producing self-employment income include, but are not limited to:

(a) costs of materials and supplies;

(b) business travel, but not personal commuting expenses, calculated at $0.25 per mile, unless the self-employed individual can prove that the actual expense is greater;

(c) business taxes, including occupational taxes, gross receipts taxes, property taxes on a place of business other than the home, and business licenses.

(d) rental of equipment, tools, and machinery;

(e) rent expense for the place of business, except for the place of business when the individual operates the business out of the individual's residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(f) payments on the principal of the purchase price of income producing real estate and capital assets, machinery, equipment and other durable goods;

(g) interest paid to purchase income producing property.

(2) Expenses and costs not allowed:

(a) Costs for depreciation, personal business, entertainment expenses, personal transportation to and from work.

(b) Expenses or costs of self-employment that are reimbursed by other agencies cannot also be claimed as costs of self-employment, such as but not limited to, reimbursements made through USDA to individuals who provide home child care.

(3) Expenses or costs that exceed self-employment income shall not be deducted from other income.

C. Work incentive deduction:

(1) To qualify for the work incentive deduction the benefit group member must be a parent of a dependent child included in the benefit group or the caretaker relative of a dependent child included in the benefit group whose parent does not live in the home, or the legal spouse of such parent or caretaker relative.

(2) Allowing the deduction: The work incentive deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for the parent in a single-parent benefit group;

(b) $225 and one-half of the remainder for each parent in a two-parent group;

(c) $125 and one-half of the remainder for a benefit group member in a single-parent or two-parent benefit group who is not a parent; and

(d) $125 for a non-benefit group members whose income is deemed available.

D. Child care costs: Out of pocket expenses for child care that is necessary due to employment of a benefit group member shall be allowed.

(1) From earnings remaining after allowing the excess hours and work incentive deductions, deduct an amount not to exceed $200 per month for a child under age two and $175 per month for a child age two or older.

(2) If more than one parent is working, costs of child care shall be allocated to maximize the available deduction to the benefit group.

(3) The total amount deducted per child, regardless of the number of benefit group members who are employed, shall not exceed the applicable limits set forth above.

E. Contributions made into approved individual development accounts: The actual amount contributed into an approved IDA from an employed benefit group member's earnings shall be an allowable deduction from earned income.
[8.102.520.12 NMAC - Rp 8.102.520.12 NMAC, 7/1/2024]

8.102.520.13 DEEMED INCOME DETERMINATION:

A. The earned and unearned income of certain non-benefit group members shall be deemed available to the eligible benefit group members. The income shall be deemed from the following:

(1) the parent of a minor parent;

(2) a participant or applicant who has been disqualified from participation

because of a failure or refusal to provide a social security number;

(3) an ineligible non-citizen.

B. Earned income deductions: An employed ineligible group member's earned income shall be allowed an earned income deduction of $125. The remainder is the net countable earned income of the non-benefit group member.

C. Unearned income: No deductions are allowed from the unearned income of a ineligible group member whose income is deemed available to the benefit group.

D. Deeming of income:

(1) The net countable earned income and all of the unearned income of a non-benefit group member shall be divided by the total number of benefit group and ineligible group members. The result is the prorated income amount.

(2) The deemed income to the eligible benefit group members shall be determined by multiplying the prorated income amount by the number of eligible benefit group members. The non-benefit group member's share of the prorated income shall be excluded from consideration.

[8.102.520.13 NMAC - Rp 8.102.520.13 NMAC, 7/1/2024]

8.102.520.14 NET EARNED INCOME: The income remaining after all allowable exemptions and deductions shall be made from the earned income of benefit group members, plus the deemed income to the benefit group, shall be the net countable earned income of the benefit group. The net countable income shall be used to determine the cash assistance payment to the benefit group.

[8.102.520.14 NMAC - Rp 8.102.520.14 NMAC, 7/1/2024]

8.102.520.15 UNEARNED INCOME:

A. Definition of unearned income: Unearned income means old age, survivors, and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income. Unearned income is not subject to deductions.

B. Special conditions:

(1) Direct receipt of child support: Child support payments directly received and retained by the benefit group are considered available to the benefit group in their entirety.

(2) Real property income: Income from real property is considered as unearned income when the benefit group engages in the management of the property less than 20 hours a week. The benefit group shall take all appropriate steps to utilize real property in a manner that will produce maximum benefits for the benefit group's maintenance. Costs associated for maintenance of the property or the production of income for which the benefit group is responsible are deducted from the income received for the use of the property.

(3) Non-citizen sponsor income: All of the income of the non-citizen sponsor and sponsor's spouse is counted as unearned income to the benefit group.

[8.102.520.15 NMAC - N, 07/01/2001; A, 11/15/2007]

HISTORY OF 8.102.520 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD FA 430, Income, 2/11/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.520 Eligibility Policy - Income, - Repealed, 07/01/2001.

8.102.520 NMAC - Eligibility Policy - Income (filed 6/18/2001) Repealed, effective 7/1/2024.

Other: 8.102.520 NMAC - Eligibility Policy - Income (filed 6/18/2001) Replaced by 8.102.520 NMAC - Eligibility Policy - Income, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 610 DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT DELIVERY

8.102.610.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.102.610.1 NMAC - Rp 8.102.610.1 NMAC, 7/1/2024]

8.102.610.2 SCOPE: The rule applies to the general public.

[8.102.610.2 NMAC - Rp 8.102.610.2 NMAC, 7/1/2024]

8.102.610.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico

Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. 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.

[8.102.610.3 NMAC - Rp 8.102.610.3 NMAC, 7/1/2024]

8.102.610.4 DURATION: Permanent.

[8.102.610.4 NMAC - Rn 8.102.610.4 NMAC, 07/01/2001]

8.102.610.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.102.610.5 NMAC - Rp 8.102.610.5 NMAC, 7/1/2024]

8.102.610.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

[8.102.610.6 NMAC - Rp 8.102.610.6 NMAC, 7/1/2024]

8.102.610.7 DEFINITIONS: [**RESERVED**]

[8.102.610.7 NMAC - Rp 8.102.610.7 NMAC, 7/1/2024]

8.102.610.8 CASH ASSISTANCE:

A. Method of payment: Cash assistance benefits are paid by issuing funds into an EBT transfer account.

B. Initial issuance: The EBT card is issued to the payee or designated authorized representative during the application process prior to the application being approved. The applicant or participant shall receive training on the use of the EBT card prior to activation of the EBT card.

C. Replacement card: The caseworker, the HCA EBT help desk or the contractor customer service help desk shall have the card deactivated once reported by participant that the card is lost, stolen, or destroyed. The card will be deactivated immediately and a replacement card provided to the participant. Once the card is deactivated, it cannot be reactivated for any reason.

D. Authorizing payments:

(1) Cash assistance benefits are authorized, changed, and terminated through the automated benefit delivery system.

(2) Initial payments are issued on the first mailing day following authorization. In the case of EBT, the transfer of funds takes place on the first working day after the day of authorization.

E. Initiation of payment:

(1) Payment is initiated and prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(2) If the case was eligible in a month prior to the month of approval but is not eligible for payment in the month following the month of disposition, the benefit group is not eligible for payment in any of these months.

(3) Payments effective in the current month: A payment that is issued during the month is deposited into the EBT account no later than the business day after payment is approved.

(4) Payments effective in the ongoing month:

(a) When authorized, the payment amount remains the same from month to month until changed.

(b) EBT issuances are transmitted to the fiscal agent so that the funds are available on the first working day of the month. Payments authorized after the monthly transmission to the fiscal agent are issued as part of the next nightly benefit batch.

F. Change in amount of payment:

(1) Following approval, there is a continuing responsibility on the part of both the participant and the caseworker to make sure that eligibility and benefit amount are correctly determined. Failure on either side to recognize and carry out this responsibility can result in overpayment to the participant. Overpayments are charged to the participant regardless of fault.

(2) A participant's assistance grant shall be increased or decreased after receipt of information indicating that changes in a participant's circumstances may affect the amount of assistance to which the participant is entitled.

(3) Changes in the payment amount shall be made in accordance with changes in program

policy.

G. Regular changes: A change in the benefit group circumstance may change the amount for which the group is eligible.

H. Other changes: If a change occurs which cannot be processed before the benefits issuance run, an overpayment or underpayment may occur. If an underpayment occurs, it shall be corrected by issuing a supplemental payment. In case of an overpayment, an overpayment claim shall be filed and appropriate efforts shall be made to recover the overpayment.

I. Whereabouts unknown: Benefits shall be terminated if the whereabouts of the benefit group are unknown to the HCA. A benefit group's whereabouts shall be considered to be unknown if:

(1) mail sent to the last known address is returned to the HCA indicating that the benefit group no longer lives at that address and at least 30 days have passed since the caseworker sent the mail; or

(2) the participant does not make any withdrawals from the participant 's EBT account for 60 days or more.

J. Death of client:

(1) Payment: Payment may be made on behalf of a client who has been approved for cash benefits but has died before an EBT withdrawal was made. If the client was alive on the first day of the month for which cash assistance benefits were issued and all eligibility conditions were met at the time of death, then another person may be authorized to use the deceased recipient's benefits. A person authorized to use the deceased recipient's benefits must be the surviving spouse, next of kin, or a person with responsibility for the deceased recipient's affairs.

(2) Withdrawing EBT benefits: When payment is made in accordance with these circumstances, the county office shall not restrict or dictate the use of the money paid.

(3) ISD may authorize the issuance of a replacement EBT card to the person authorized to use the deceased recipient's benefits.

(4) EBT transactions shall not be in any liquor store; any casino, gambling establishment; or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.
[8.102.610.8 NMAC - Rp 8.102.610.8 NMAC, 7/1/2024]

8.102.610.9 [RESERVED]
[8.102.610.9 NMAC - Rp 8.102.610.9 NMAC, 7/1/2024]

8.102.610.10 SUPPORTIVE SERVICES:

A. The NMW work program provides supportive services on an ongoing basis, provided that the participant is eligible to receive the services during the month provided.

B. Participants must meet minimum participation requirements in order to receive supportive services reimbursements. Reimbursement for supportive services is issued by EBT payment to the benefit group in accordance with 8.102.620.14 NMAC thru 8.102.620.17 NMAC.
[8.102.610.10 NMAC - Rp 8.102.610.10 NMAC, 7/1/2024]

8.102.610.11 [RESERVED]
[8.102.610.11 NMAC - Rp 8.102.610.11 NMAC, 7/1/2024]

8.102.610.12 DIVERSION PAYMENTS TO A NMW BENEFIT GROUP: The diversion payment is a non-recurring lump sum payment, issued to the recipient's EBT account in accordance with eligibility and amount specified at 8.102.500.10 NMAC.
[8.102.610.12 NMAC - Rp 8.102.610.12 NMAC, 7/1/2024]

8.102.610.13 [RESERVED]
[Education Works Program now filed at 8.102.611 NMAC]

HISTORY OF 8.102.610 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 271.0000, Procedures Applicable to Payment and Related Changes, 5/16/1980.
ISD FA 450, Payment, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.610 NMAC Description of Program/Benefits - Benefit Delivery - Repealed, 07/01/2001.
8.102.610 NMAC - Description Of Program/Benefits - Benefit Delivery (filed 6/18/2001) - Repealed effective 7/1/2024.

Other: 8.102.610 NMAC - Description Of Program/Benefits - Benefit Delivery (filed 6/18/2001) Replaced by 8.102.610 NMAC - Description Of Program/Benefits - Benefit Delivery, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 611 EDUCATION WORKS PROGRAM

8.102.611.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.611.1 NMAC - Rp 8.102.611.1 NMAC, 7/1/2024]

8.102.611.2 SCOPE: The rule applies to the general public.
[8.102.611.2 NMAC - Rp 8.102.611.2 NMAC, 7/1/2024]

8.102.611.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works (NMW) program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its financial assistance programs, and in accordance with the Education Works Act of 2003 the education works program (EWP) was created.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at title 7, code of federal regulations.

F. 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.
[8.102.611.3 NMAC - Rp 8.102.611.3 NMAC, 7/1/2024]

8.102.611.4 DURATION: Permanent.
[8.102.611.4 NMAC - Rp 8.102.611.4 NMAC, 7/1/2024]

8.102.611.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.611.5 NMAC - Rp 8.102.611.5 NMAC, 7/1/2024]

8.102.611.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide financial assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long -term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

C. 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 like NMW or the federal program of supplemental security income (SSI).

D. 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.

E. The objective of the burial assistance program is to assist in payment of burial expenses for deceased, low-income individuals.
[8.102.611.6 NMAC - Rp 8.102.611.6 NMAC, 7/1/2024]

8.102.611.7 DEFINITIONS: [**RESERVED**]

8.102.611.8 EDUCATION WORKS ASSISTANCE PAYMENTS:

A. Method of payment: Cash assistance benefits are paid by deposit of funds into an EBT account. In some circumstances benefits may be issued by warrant.

B. Authorizing payments:

(1) FA benefits are authorized, changed, and terminated through the automated benefit delivery system.

(2) Initial payments are issued on the first mailing day following authorization. In the case of EBT, the transfer of funds takes place on the first working day after the day of authorization.

C. Initiation of payment:

(1) Payment is initiated and prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(2) If the case was eligible in a month prior to the month of approval but is not eligible for payment in the month following the month of disposition, the benefit group is not eligible for payment in any of these months.

(3) Payments effective in the current month: Payments authorized during the month are written the night the information is entered into the computerized system and mailed the first business day following authorization. Cash assistance benefits are deposited into the EBT account the business day after payment is authorized.

(4) Payments effective in the coming month:

(a) When authorized, the payment amount remains the same from month to month until changed. Ongoing payments are written or authorized in the regular “monthly check write” process. During the monthly check write, hard copy checks are written the night before the third to the last working day of the month. They are mailed so as to arrive on the first mail delivery day of the month.

(b) EBT deposits are transmitted to the fiscal agent so that the funds are available on the first working day of the month. Payments authorized after

the monthly check write are issued on the next nightly benefit write.

D. Change in amount of payment:

(1) Following approval, there is a continuing responsibility on the part of both the recipient and the caseworker to make sure that eligibility and benefit amount are correctly determined. Failure on either side to recognize and carry out this responsibility can result in overpayment to the recipient. Overpayments for any reason are charged to the recipient.

(2) A recipient's assistance grant shall be increased or decreased after receipt of information indicating that changes in a recipient's circumstances may affect the amount of assistance to which the recipient is entitled.

(3) Changes in the payment amount shall be made in accordance with changes in program policy, assistance standards, or adequacy with which need may be met.

E. Regular changes: A change in the benefit group circumstance may change the amount for which the group is eligible.

F. Other changes: If a change occurs which cannot be processed before the benefits issuance run, an overpayment or underpayment may occur. If an underpayment occurs, it shall be corrected by issuing a supplemental payment. In case of an overpayment, an overpayment claim shall be filed and appropriate efforts shall be made to recover the overpayment.

G. Whereabouts unknown: Benefits shall be terminated if the whereabouts of the recipient are unknown to the HCA for 30 days or more. A recipient's whereabouts shall be considered to be unknown if:

(1) mail sent to the recipient's last known address is returned to the HCA indicating that the recipient no longer lives at that address; or

(2) the recipient does not make any withdrawals from the recipient's EBT account for 90 days or more.

H. Recovery of unused education works program (EWP) funds: Beginning January 1, 2005, New Mexico will recover EWP funds that remain unused in EBT accounts for over 180 days.

(1) Clients will be notified of the agency's intention to close EWP cases that are not in use at 90 days.

(2) After case closure, the case head will be notified at 135 days of the HCA's intention to recover unused EWP funds that remain in inactive accounts for a period of 180 days.

(3) Each complete month of recovered funds will be removed from the 24 months limit for EWP.

[8.102.611.8 NMAC - Rp 8.102.611.8 NMAC, 7/1/2024]

8.102.611.9 SUPPORT SERVICES:

A. Subject to the availability of state and federal funds, a benefit group that has countable gross income that is less than one hundred percent of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services.

B. Any month that an EWP participant receives support services will count towards the 60 month temporary assistance to needy families (TANF) lifetime limit if the EWP benefit group has no earned income in accordance with Paragraph (4) of Subsection A of 8.102.410.17 NMAC.

C. Support services for child care will be issued in accordance with Subsection A of 8.102.620.15 NMAC.

[8.102.611.9 NMAC - Rp 8.102.611.9 NMAC, 7/1/2024]

8.102.611.10 EDUCATION WORKS CASH ASSISTANCE:

A. Subject to the availability of allocated state funds, the education works program (EWP) provides state-funded cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. The applicant or recipient benefit group must be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

(1) The state-funded benefit amount is determined based on the same determination used to calculate the benefit amount in the NMW cash assistance program.

(2) During the initial application or recertification process, the caseworker shall screen an applicant for eligibility for the EWP. The caseworker shall explain the EWP to applicants who have applied for NMW cash assistance or NMW recipients who are applying for continued assistance. The HCA's work program contractor may screen recipients of NMW cash assistance for eligibility for participation in the EWP and make a referral to the caseworker for transition to the EWP.

(3) An individual shall not have a month of participation in the EWP applied to the 60-month term limit for receipt of benefits in the state's TANF program.

(4) A benefit group participating in the EWP is considered to meet the categorical eligibility factors for the food stamp program.

(5) A benefit group participating in the EWP shall have its eligibility for medicaid determined. Eligibility shall be based on the rules in place for each medicaid program.

B. Limitations of the education works cash assistance program:

(1) The number of participants in the EWP shall be limited to the number for which state funding is allocated.

(2) Recipients who are actively participating in the NMW cash assistance program, and who meet the requirements for the EWP, shall be given first opportunity to switch programs.

(3) A benefit group shall not participate in the NMW and EWP simultaneously.

(4) A benefit group with income from employment

may receive support services funded by the federal TANF block grant. A benefit group that does not have income from employment shall not be eligible to receive support services funded by the TANF block grant.

(5) A recipient may participate in the EWP for no more than 24 months, whether or not consecutive, except:

(a) that a recipient may participate in the EWP for one additional academic term following the 24 month participation limit if doing so will result in the recipient earning a degree, or

(b) that a recipient may participate in the EWP for two additional academic terms following the 24 month participation limit at the discretion of the director if doing so will result in the recipient earning a degree.

(6) A participant must be a full-time student as defined by the educational institution.

C. Eligibility criteria:

(1) Conditions: Eligibility for participation in the EWP shall be based on all eligibility criteria for the NMW cash assistance program. As a condition of approval, an applicant or recipient must:

(a) be otherwise eligible for NMW cash assistance;

(b) be in good standing with the HCA; good standing means that sanctions are not currently applied to the benefit group due to noncompliance with work programs, child support enforcement or reporting requirements;

(c) provide proof that the applicant or recipient has been accepted or is enrolled in a two-or four-year post-secondary, graduate or post-graduate degree education program;

(d) apply for all financial aid available, including grants and scholarships.

(2) Level of effort:

(a) A participant must engage in a combination of education, training, study or work-site experience, for an average of 20 hours a week in each month of participation in the EWP.

(b) One and one-half hours of study time shall be credited for each hour of class time.

(c) Work-site experience includes, but may not be limited to, paid employment, work study, training-related practicums, an internship, a clinical placement, or laboratory or field work, or any other work activity pursuant to the NMW cash assistance program.

D. Satisfactory participation in the education works program:

(1) To maintain satisfactory participation in the EWP, a participant shall meet all the requirements and standards of the educational institution that the participant attends, including class attendance.

(2) A participant shall maintain a 2.0 grade point average in each school term.

E. Reporting requirements for recipients:

(1) A recipient must provide ISD with proof of the recipient's final grades for each school term. Final grades must be provided by the end of the month in which the school term ends.

(2) A recipient must provide ISD with a copy of all letters relating to the receipt or denial of financial aid.

(3) A recipient must report to ISD when the recipient intends to drop out of school.

(4) A recipient must report any circumstance that might affect the recipient's ability to participate in the EWP.

(5) School attendance and reporting requirements for dependent children apply to the EWP.

(6) All reporting requirements in the NMW cash assistance program apply to the EWP.

[8.102.611.10 NMAC - Rp 8.102.611.10 NMAC, 7/1/2024]

8.102.611.11 WORK PROGRAM REQUIREMENTS:

A. New applicant responsibilities:

(1) The individual shall have an assessment completed and shall provide verification within 15 days following approval to the EWP.

(2) The individual shall complete a WPA to enter the EWP for the level of effort required of participants. The WPA shall be submitted to ISD no later than 60 days from the date of approval of assistance

(3) ISD and participant shall develop an individual education plan (IEP) in compliance with the EWP cash assistance program's requirements for an IEP. The IEP shall be submitted to ISD no later than 60 days from the date of approval of assistance. The IEP:

(a) shall contain documentation, including, but not limited to, acceptance into a particular area of study that supports the recipient's ability to succeed in the educational program that was chosen;

(b) shall describe how the degree will increase the individual's ability to engage in full-time paid employment.

(4) Currently participating in the NMW cash assistance program: Individuals currently participating in the NMW cash assistance program shall have until the end of the first full month of participation in the EWP to submit a revised WPA and IEP to ISD.

(5) Two-parent family: In a two-parent family where only one of the parents is a participant in the EWP, the other parent, if considered as a mandatory participant in the NMW work program, shall be required to participate in qualified work activities for a minimum of 30 hours per week. At least 20 hours a week must be spent in qualified primary work activities.

B. Changes affecting

participation in the EWP:

(1) 24 month time limit: Participation in the EWP shall be limited to 24 months, whether or not consecutive, except

(a) that a recipient may participate in the EWP for one additional academic term following the 24month participation limit if doing so will result in the recipient earning a degree, or

(b) that a recipient may participate in the EWP for two additional academic terms following the 24 month participation limit at the discretion of the director if doing so will result in the recipient earning a degree; all requests submitted to the director for approv

(i) verification of satisfactory participation in the education works program and

(ii) verification that the additional academic terms will lead to a degree.

(2) Leaving the program:

(a) A participant who leaves the program for a good cause reason may resume participation when the individual is able and ready to return to the EWP.

(b) An individual who leaves the program on a voluntary basis, and good cause is not established, is not eligible to resume participation in the EWP.

(3) Unsatisfactory participation:

(a) A participant who falls below the standards set by the educational institution at the end of the school term shall be placed on probationary status for the following semester. The participant shall be required to become compliant with the standards set by the educational institution, including improving grades, during the probationary period.

(b) Where the participant's overall GPA for the school term falls below 2.0, the individual shall be placed on probationary status for the following school term in order to bring the overall GPA to 2.0 or better.

(4) State funding limitation: Participation in the EWP may be limited should state funding for the program be reduced or terminated.

(5) Failure to comply with other requirements: The benefit group shall be transitioned back to the NMW cash assistance program and appropriate sanctions applied if a participant fails or refuses to comply with child support enforcement, school attendance, and reporting requirements in the NMW cash assistance program. The transition is effective in the month following the month the failure or refusal to comply is established.

C. Establishing good cause for failure to meet requirements:

(1) Good cause for not meeting the requirements for participation in the EWP is determined on an individual basis. Good cause may be applied to the 20-hour-a-week requirement to engage in education activities, or to a situation that causes a participant to leave the program.

(2) Good cause means that there are circumstances in which the required participation would cause the participant to seriously compromise academic performance. Good cause for leaving the EWP includes academic deficiency as long as the student has consulted with the contractor, all options have been discussed, and the contractor and ISD approve of the action.

(3) Good cause includes, but may not be limited to, a verified situation requiring the participant to care for a family member with special needs; a physical or mental health problem; a chronic illness; accident; death; or a serious personal or family problem that necessitates reducing or ending participation in the EWP.

(4) Good cause for failure to meet requirements may be determined by the contractor or ISD. Final approval of good cause is determined by the ISD.

[8.102.611.11 NMAC - Rp 8.102.611.11 NMAC, 7/1/2024]

8.102.611.12 TERMINATING PARTICIPATION IN THE EDUCATION WORKS PROGRAM:

A. The HCA shall take action to terminate an individual's participation in the EWP, or to require an individual to apply for NMW cash assistance, by issuing an advance written notice under the following conditions:

(1) copies of financial aid award or denial letters are not provided;

(2) copies of final grades are not provided;

(3) there is a failure or refusal to comply with reporting requirements of the EWP;

(4) at the end of the probationary period, a participant's grade point average is not 2.0 or better;

(5) at the end of the probationary period, a participant has failed or refused to comply with the standards set by the educational institution, including class attendance;

(6) the participant fails or refuses, without good cause, to participate in education activities for at least 20 hours a week averaged over the month;

(7) funding for the EWP has been exhausted;

(8) an individual participating in the EWP has received a bachelor's degree.

B. Appeal rights: A participant shall have an opportunity to appeal an adverse action taken by the HCA in the EWP. Appeals are handled pursuant to the appeal process currently in place for programs administered by the health care HCA's ISD.

[8.102.611.12 NMAC - Rp 8.102.611.12 NMAC, 7/1/2024]

HISTORY OF 8.102.611 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives: ISD 271.0000, Procedures Applicable

to Payment and Related Changes, 5/16/1980.
ISD FA 450, Payment, 2/10/88.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.610 NMAC Description of Program/Benefits - Benefit Delivery - Repealed, 07/01/2001.
8.102.611 NMAC - Education Works Program (filed 11/30/2005) - Repealed effective 7/1/2024.

Other History:
8.102.610 NMAC, Section 12, Education Works Cash Assistance replaced by 8.102.611 NMAC, Education Works Program, effective December 15, 2005.
8.102.611 NMAC - Education Works Program (filed 11/30/2005) Replaced by 8.102.611 NMAC - Education Works Program, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 620 DESCRIPTION OF PROGRAM BENEFITS - BENEFIT DETERMINATION/ GENERAL

8.102.620.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.620.1 NMAC - Rp 8.102.620.1 NMAC, 7/1/2024]

8.102.620.2 SCOPE: The rule applies to the general public.
[8.102.620.2 NMAC - Rp 8.102.620.2 NMAC, 7/1/2024]

8.102.620.3 STATUTORY AUTHORITY:

A. 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.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. 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.
[8.102.620.3 NMAC - Rp 8.102.620.3 NMAC, 7/1/2024]

8.102.620.4 DURATION: Permanent.
[8.102.620.4 NMAC - Rp 8.102.620.4 NMAC, 7/1/2024]

8.102.620.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.102.620.5 NMAC - Rp 8.102.620.5 NMAC, 7/1/2024]

8.102.620.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.620.6 NMAC - Rp 8.102.620.6 NMAC, 7/1/2024]

8.102.620.7 DEFINITIONS: [**RESERVED**]
[8.102.620.7 NMAC - Rp 8.102.620.7 NMAC, 7/1/2024]

8.102.620.8 CASH ASSISTANCE BENEFITS:

A. The cash assistance grant shall be determined by subtracting the benefit group's countable income from the standard of need applicable to the benefit group as indicated in 8.102.520 NMAC.

B. The payment made to the benefit group shall be determined by subtracting certain amounts from the grant if the group is subject to payment sanctioning or recoupment of an overpayment. The amount left over after these amounts are deducted from the amount of payment shall be issued to the benefit group.
[8.102.620.8 NMAC - Rp 8.102.620.8 NMAC, 7/1/2024]

8.102.620.9 GRANT DETERMINATION:

A. Determining the payment standard: The payment standard shall be determined based on the eligibility standards and

requirements forth in 8.102.500.8 NMAC. The payment standard also includes the special clothing allowance.

B. Determining benefit group income: The benefit group's net countable income considered in the payment determination shall be the sum of:

(1) gross non-citizen sponsor income;

(2) countable earnings after allowable deductions and disregards of benefit group members; and

(3) gross unearned income of benefit group members;

(4) the net income calculation is rounded down removing the cents.

C. Determining the grant: A benefit group whose countable income after allowed deductions and disregards equals or exceeds the standard of need applicable to the benefit group shall not be eligible for payment. The grant shall be a monthly benefit amount determined by subtracting the benefit group's net countable income from the payment standard applicable to the benefit group.

[8.102.620.9 NMAC - Rp 8.102.620.9 NMAC, 7/1/2024]

8.102.620.10 CHILD SUPPORT AND NMW NON-COOPERATION PAYMENT SANCTIONS:

A. General:

(1) The benefit group shall be subject to a non-cooperation payment sanction under either or both of the following circumstances:

(a) failure by a benefit group member to meet NMW requirements; or

(b) failure by the adult responsible for children included in a benefit group to meet child support services division (CSSD) cooperation requirements or both;

(c) good cause will be evaluated based on the circumstances of each instance of non-cooperation.

(2) Occurrence of non-cooperation:

(a) Child support:

(i) A benefit group shall be subject to a payment sanction for failure to comply with CSSD cooperation requirements, even if the adult required to cooperate with child support requirements is not included in the benefit group.

(ii) Each benefit group member that fails to cooperate with the NMW requirement is subject to a sanction and shall affect the benefit group.

(iii) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(iv) A first or second level sanction is considered to be cured upon full cooperation by the sanctioned participant or a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(b) NMW:

(i) A benefit group is subject to a payment sanction when a participant in the benefit group fails to cooperate with the NMW requirements absent a finding of good cause.

(ii) In a two-parent benefit group, each mandatory benefit group member that fails to cooperate with the NMW requirements is subject to a sanction that affects the benefit group's sanction level and payment.

(iii) A participant shall not be sanctioned for more than one NMW requirement element at one time. A participant may be sanctioned for the same or a different NMW requirement element only after the original sanction element is cured or reversed. A first or second level sanction may be cured upon full cooperation by the sanction participant and a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(iv) A participant with limited participation status may not be sanctioned for failure to meet hours or failure to provide a time sheet as identified on the approved work participation agreement.

(v) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(3) Cumulative sanctions:

(a) Non-cooperation sanctions are cumulative within the benefit group and shall occur when:

(i) the participant fails to comply with the NMW and child support enforcement requirements;

(ii) more than one participant in the benefit group have failed to comply with either the NMW or child support enforcement requirement.

(b) Cumulative sanctions, whether or not cured, shall remain the property of that benefit group participant who caused the sanction.

(i) A participant with a sanction who leaves a benefit group relieves the benefit group of that participant's sanction status.

(ii) A participant with a sanction who joins another benefit group subjects the new benefit group to any sanction or sanction level that has not been cured prior to joining the benefit group.

(c) The benefit group's cumulative sanctions and benefit level shall be

reevaluated when a sanction is cured or reversed.

(4) Progressive sanctions:

(a) Non-cooperation sanctions are progressive to both the participant and to the benefit group and shall progress to the next level for the benefit group in which the sanctioned participant resides when:

(i) a participant fails to establish compliance in three-month increments; or

(ii) a participant fails to comply with NMW or CSSD requirements as a separate occurrence.

(b) A sanction that is not cured for three consecutive months shall progress until compliance is established by the participant.

(c) A participant's compliance cannot reverse the sanction level attributed to the benefit group. Any subsequent sanction is imposed at the next higher level, unless reversed by a hearing decision.

B. The conciliation process:

(1) When conciliation is available: Conciliation shall be available to a participant or applicant once during an occurrence of assistance. There must be a period of at least 12 months between occurrences of cash assistance in order for a conciliation to be available again to the benefit group. NMW conciliation and child support conciliation are independent and are counted separately from each other.

(2) Determining that noncompliance has occurred:

(a) The determination of noncompliance with child support shall be made by CSSD. The conciliation and sanctioning process for child support noncompliance is initiated upon receipt of notice from CSSD that the participant or applicant has failed to cooperate. Under 8.102.420 NMAC, the non-cooperative participant or applicant shall be individually disqualified from participation in the benefit group.

(b) The determination of noncompliance with NMW requirements shall be made by the caseworker. A finding of noncompliance shall be made if:

(i) the participant has not completed an assessment;

(ii) the participant fails or refuses to complete an IRP;

(iii) the participant fails or refuses to submit an approvable WPA;

(iv) the participant fails to submit timely documentation showing completion of required work hours;

(v) the participant's monthly attendance report shows fewer than the minimum required hours of participation and no other allowable hours of activity can be reasonably attributed by the caseworker towards the monthly participation requirement.

(3) Initiating conciliation: Within 10 days of determining that noncompliance exists, the caseworker shall take action to initiate a conciliation, if the participant's conciliation has not been used. A conciliation is initiated by the HCA or its designee issuing a conciliation notice. CSSD shall determine noncompliance and notify the caseworker who shall initiate the conciliation process.

(4) Conciliation period: Conciliation gives a participant a 30-calendar day period to correct the current non-compliance for either a NMW participation or CSSD requirement.

(a) The conciliation process is established by the HCA, to address the noncompliance, identify good cause for noncompliance or barriers to compliance and shall occur only once prior to the imposition of the sanction.

(i) The participant shall have 10 working days from the date a conciliation notice is mailed to contact the HCA to initiate the conciliation process. A participant who fails to initiate the conciliation process shall have a notice of adverse action mailed to them after the 10th working day following the date on which the conciliation notice is mailed.

(ii) Participants who begin but do not complete the conciliation process shall be mailed a notice of adverse action 30 days from the date the original conciliation was initiated. The benefit group shall be subject to sanction in the month following the month the notice of adverse action expires.

(b) Non-cooperation with CSSD requirements: When the participant has initiated the conciliation process, it is the participant's responsibility to contact CSSD and to comply with requirements or to request a waiver from CSSD due to good cause. If the caseworker does not receive confirmation from CSSD within 30 days of issuing the conciliation notice that the participant is cooperating or has requested a waiver for good cause in accordance with 8.50.105.14 NMAC; the conciliation process shall be considered to have failed and the benefit group shall be subject to payment sanctioning.

(c) The caseworker shall make the determination whether arrangements have been made to meet NMW requirements or whether there is good cause for waiving the cooperation requirements. If arrangements to meet the requirement or to waive it have not been made by the 30th day following issuance of the conciliation notice, the conciliation shall be considered to have failed and the participant is subject to sanctioning.

C. Sanctioning:

(1) Within 10 days of determining that a participant has failed to meet a NMW requirement, HCA or its designee shall issue notice of adverse action that the payment shall be reduced. The payment reduction shall take place with the first payment following expiration of the notice of adverse

action.

(2) Notice of adverse action shall apply to all NMW and child support noncompliance sanctions, including those relating to the conciliation process.

(3) A participant who corrects the failure of compliance with NMW or child support enforcement requirements during the notice of adverse action 13-day time period shall not have the sanction imposed against the benefit group or payment amount. The sanction shall not count as a cumulative or progressive sanction, since the reason for the sanction was corrected during the time period of the notice of adverse action and prior to a benefit reduction being imposed. A participant who has failed to meet work participation hours cannot correct the sanction during the notice of adverse action time period.

(4) Failure to comply during the notice of adverse action 13-day time period shall cause the sanction to become effective for a minimum of one month. If the participant later complies with the NMW compliance requirements, as determined by the HCA, the sanction may be removed, so long as the participant has received at least one month of reduced benefit due to sanction.

(a) A child support enforcement sanction shall be removed after CSSD notifies the caseworker that the participant is in compliance with child support enforcement requirements.

(b) A NMW sanction shall be removed after the caseworker receives verification that the participant has completed an assessment; or has completed an IRP; or has completed a WPA that indicates the appropriate number of monthly hours in work activities; or has met NMW participation hours for at least 30 days; or has good cause to waive work participation requirements.

D. Sanction levels:

(1) First-level sanction:

(a) The first level sanction for failure to comply shall result in a sanction of twenty-five percent of the standard of need. The benefit group shall be given notice of the imposition of the sanction.

(b) A first level sanction that is not cured for three consecutive months shall progress to a second level sanction.

(2) Second-level sanction:

(a) The second level of sanction for failure to comply shall result in a decrease of fifty percent of the standard of need. The second level shall be initiated by:

(i) failure to comply with NMW participation or child support enforcement requirements for more than three months; or

(ii) a second occurrence of noncompliance with a NMW or CSSD requirement by a participant; or

(iii) failure of a participant to comply with both CSSD and NMW participation requirements simultaneously. The group shall be given concurrent notice of imposition of the second-level sanction.

(b) A second level sanction that is not cured for three consecutive months shall progress to the third level as described below.

(3) Third-level sanction:

(a) The third sanction level is case closure for a period of not less than six months. The group shall be given notice of adverse action prior to imposition of the sanction.

(i) Once a participant is sanctioned at the third level, any subsequent occurrence of failure to comply with NMW or CSSD requirements shall immediately result in a third level sanction, and case ineligibility for six months.

(ii) The TANF grant will be counted as unearned income for SNAP benefits for the six month period of ineligibility in accordance with 8.139.520 NMAC.

(b) TANF applications received after a six month closure period will be reviewed for eligibility.

(i) Based on eligibility the TANF will be approved and all mandatory members will be required to meet the NMW compliance requirements set forth in 8.102.460 NMAC;

(ii) If ISD determines the applicant is still non-compliant with CSSD, the sanction will remain and the application will be denied.

E. Sanctions by other states or other programs: Participants in sanction status for failure to participate in other programs, such as the food stamp E&T program, or another state's or tribal TANF program, shall not carry that sanction status into NMW.

F. Sanctions with respect to voluntary participants: A voluntary participant is not subject to sanction for failure to participate, but shall be removed from the NMW and lose eligibility for support services

G. Good cause:

(1) Good cause applies to timely completion of assessment, IRP, WPA, work participation rates, and cooperation with the child support services division.

(2) Good cause for failure to meet the NMW requirements.

(a) Good cause may be considered to exist for no more than 30 days in the event of:

(i) family death;

(ii) hospitalization;

(iii) major injury to the participant or a benefit group member for whom the participant has been the primary caretaker;

(iv) reported domestic violence;

(v) catastrophic event; or

(vi) it is shown the HCA did not provide

the participant reasonable assistance to complete the assessment, IRP, or WPA.

(b) The participant must meet with the NMW service provider prior to the end of the 30-day period to establish a WPA for the full participation standard beginning on day 31 or must request a limited work participation status prior to the end of the 30-day period. The participant may be subject to sanction for failure to complete a WPA if a new WPA has not been established by day 31.

(i) A participant with good cause for failure to meet the NMW requirements, who expects the cause of failure to continue for more than 30 days, must contact the HCA to review the participant's circumstances.

(ii) Under no conditions shall good cause be granted for more than 30 days during any given reporting period.

(3) Good cause shall be considered when the HCA has failed to submit a notice in accordance with the requirements of adverse action notices, to the participant or provide available support services that would adversely affect the participant's ability to timely meet work participation requirements.

(4) Good cause for refusal to cooperate with the child support enforcement requirements: In some cases it may be determined by the CSSD that the TANF/NMW applicant's/recipient' refusal to cooperate is with good cause in accordance with 8.50.105.14 NMAC. Any person requesting a good cause exemption to a TANF/NMW requirement to cooperate must complete a request for a good cause exemption on a form provided by the CSSD and provide any documentation requested by CSSD. The request for a good cause exemption will be reviewed by the CSSD and the requestor will be informed of the decision in writing. The requestor's failure or refusal to complete the form or provide the requested documentation will result in an automatic denial of the request. The HCA may offer assistance to complete the form or obtain the necessary documentation, as appropriate.

(5) It is the applicant's/recipient's responsibility to inform the HCA if they are unable to meet the NMW compliance requirements or CSSD cooperation requirements.

[8.102.620.10 NMAC - Rp 8.102.620.10 NMAC, 7/1/2024]

8.102.620.11 NON-REPORTING SANCTIONS:

A. General: The eligibility determination and payment calculation process relies upon applicants and participants to provide accurate and timely reports of information affecting their eligibility and payment. Payment sanctions for non-reporting shall be established to encourage timely and accurate reporting and to offset benefits resulting from the reporting of inaccurate or misleading information, the untimely reporting of changes, or the failure to report any required information.

B. Non-reporting sanctions:

(1) Length of sanction: Each non-reporting sanction shall run for a period of four months beginning with the first month in which failure to report occurred. An additional month shall be added for each additional month of non-reporting until the payment is corrected.

(2) Definition of an occurrence of non-reporting: An occurrence of non-reporting exists when an applicant or participant who fails to report information or reports incorrect information which results in an overpayment of cash assistance benefits for which the participant is at fault.

(3) Amount of sanction:

(a) Reporting sanctions shall be calculated at twenty-five percent of standard of need for the size of the benefit group being sanctioned.

(b) Reporting sanctions are not progressive. If there is another occurrence of non-reporting prior to the end of a non-reporting sanction period, the next and any subsequent non-reporting sanctions shall be consecutive and at the twenty-five percent level.

(c) Reporting sanctions, child support sanctions and work program sanctions shall be integrated into a single calculation to determine the final sanction amount.

(d) If a case closes during a reporting sanction period for reasons other than sanctions, the non-reporting sanction shall be suspended and resumed at the same duration the next time the case is opened.

(4) Procedures: The following steps shall be taken in implementing a payment sanction.

(a) The caseworker shall document and establish an overpayment claim using the HCA overpayment claims procedures. The caseworker shall also determine whether the participant was at fault for the overpayment.

(b) The county director or a designated supervisor shall review the overpayment and determine the accuracy of the overpayment determination and appropriateness of the determination the participant was at fault for the overpayment. Upon determining that a non-reporting sanction is appropriate, the county director, or designated supervisor shall issue a notice of intent to sanction to be issued to the participant. Failure by the participant to contact the person issuing the notice within 10 working days allowed shall constitute waiver of conciliation rights.

(c) If the participant requests conciliation within the 10 working days of issuance of the notice, the county director or designated supervisor shall schedule a conciliation conference.

(d) The conciliation conference is

conducted by the county director or designated supervisor.

(i) The caseworker shall describe the reporting error, how the amount of the overpayment is determined and the reasons for finding the participant at fault for the overpayment.

(ii) The participant shall have the opportunity to discuss the overpayment determination, the finding of fault and to show good cause why the sanction should not be imposed.

(iii) Based upon this determination, the county director or designated supervisor shall determine whether a sanction should be imposed.

(iv) The participant may represent himself or be represented by someone else. If the participant wishes to be represented by another individual, the participant must designate that individual in writing.

(e) Following the conference, the county director shall issue written notice stating whether or not the sanction is to be imposed, and the worker shall affect the sanction causing issuance of a notice of adverse action. The payment reduction takes effect in the month following expiration of the notice of adverse action.

(f) Participants who disagree with the sanction determination shall have fair hearing rights and access to legal adjudication through the fair hearing process.

[8.102.620.11 NMAC - Rp 8.102.620.11 NMAC, 7/1/2024]

8.102.620.12 RECOUPMENT: Participants and applicants with an outstanding claim for overpayment of cash assistance benefits shall be required to repay the claim. Claim and recoupment situations and procedures are detailed in 8.100.640 NMAC.

[8.102.620.12 NMAC - Rp 8.102.620.12 NMAC, 7/1/2024]

8.102.620.13 PAYMENT:

A. The grant amount remaining after deduction of sanction and recoupment amounts, if any, shall be the amount issued as payment. Any month for which a payment is issued shall be a month counted against the 60-month lifetime limit of each adult or minor head of household included in the benefit group.

B. Payment issuance: The payment for the benefit group shall be issued to the head of household, unless a protective payee has been designated by the head of household. In the event the head of household is unable or unwilling to select a protective payee, ISD shall designate the protective payee on the benefits group's behalf.

[8.102.620.13 NMAC - Rp 8.102.620.13 NMAC, 7/1/2024]

8.102.620.14 SUPPORTIVE SERVICES:

A. An explanation of the supportive services available through the NMW work program, provided funding is available, shall be given to NMW participants during orientation. Participants who need supportive services to participate in the program are eligible for such services.

B. NMW work program participants are eligible to receive an initial supportive services payment in accordance with 8.102.620.15 NMAC. The support services payment may be used by the participant to cover travel, child care costs incurred or both.

C. Ongoing supportive services:

(1) Necessary ongoing supportive services are identified on the WPA, which identifies the services needed and the start and end dates for the services.

(2) If additional supportive services are needed after the initial assessment, the WPA shall be modified to reflect the changes.

[8.102.620.14 NMAC - Rp 8.102.620.14 NMAC, 7/1/2024]

8.102.620.15 CALCULATING THE SUPPORTIVE SERVICES BENEFIT: If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

A. Child care: The caseworker may authorize child care reimbursement for persons for a period not to exceed 30 days. All other child care shall be authorized by CYFD. The caseworker shall authorize child care in compliance with CYFD program requirements and standards. Child care payments shall not be paid for with federal TANF funds and shall not count towards the TANF term limits.

B. Transportation: NMW participants may receive a standard transportation reimbursement.

(1) Reimbursement:

(a) The NMW allows travel reimbursement for mandatory and voluntary participants traveling to offices for orientation, assessment, reassessment, or employment planning activities. In addition, travel costs are reimbursed for approved NMW activities identified and developed in the WPA.

(b) Mileage costs for paid employment are met through the cash assistance earned income deduction. Except for the one-time only advance, travel reimbursement shall not be made for any NMW activity for which the individual is paid.

(2) Reimbursement standards:

(a) NMW reimbursement for NMW participants using private automobiles shall be at a standard rate based on monthly mileage, as set forth below.

(i) The caseworker shall decide whether the claimed mileage is reasonable and, if the amount claimed is excessive, may adjust the amount downward.

Monthly Mileage	Monthly Reimbursement
1 - 499	$25
500 - 1499	$50

1500 - 2499	$100
2500 or More	$150

(ii) Mileage shall be allowed only if the activity takes place in the individual's home community. Travel may be allowed outside the individual's home community only if the NMW activity is not available in the community or if the NMW activity involves participation in an educational or vocational training program which is not available in the individual's home community.

(b) Bus tokens/passes are issued in lieu of the travel allowance and may not exceed $25 for the month. A participant shall be eligible to receive bus tokens or a one-month bus pass on an interim basis, provided that:

(i) the participant has no access to private transportation; and

(ii) public transportation is a reasonable alternative.

C. Vocational training and education: If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

(1) Reimbursement for vocational training and educational expenses, but not tuition, shall be available to NMW participants.

(2) NMW participants requesting reimbursement for various vocational training and educational expenses must provide receipts or request letters stating the amount of educational expenses. In addition, NMW participants must provide verification that financial assistance from other sources is unavailable or insufficient to cover the expenses for which the reimbursement is being requested.

(3) To be eligible for reimbursement of vocational training and educational expenses, the NMW participant must:

(a) meet NMW participation requirements;

(b) have an approved WPA which identifies and approves supportive services for further training; a NMW participant is not eligible for reimbursement of vocational training or educational expenses incurred prior to development of the WPA;

(c) apply and be denied for any educational assistance from such other sources as scholarships, PELL grants, WIA, student loans, etc. for which the participant might be eligible;

(d) provide "letters of denial" for the financial assistance listed previously; and

(e) repeat steps (a) through (c) at the beginning of each educational period (semester, quarter, trimester etc. as applicable).

(4) Reimbursable vocational training and education costs shall include only those for which a student is normally responsible, such as book and laboratory fees, special laboratory or shop clothing, work book fees, testing, registration, or graduation fees. In addition, personal classroom supplies, not to exceed $15 per semester, may be reimbursed.

(5) Participants enrolled in a post-graduate studies shall not be not eligible for supportive service reimbursement with respect to their post-graduate studies.

(6) Education and vocational training supportive services cannot be guaranteed beyond the end of the WPA expiration date.

(7) Test fees: Fees for completing either the scholastic aptitude test (SAT) or the American college test (ACT) may be reimbursed, provided one of the tests is required for admission into a given educational training institution.

D. Employment-related expense: If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

(1) A NMW participant may receive assistance to help pay the cost for certain personal items necessary to accept a bona fide job offer, or to retain employment. The assistance shall be limited to no more than $300, and shall be available only once during the individual's lifetime.

(2) Payment method:

(a) Payment shall be made as a reimbursement for verified costs already incurred. Reimbursement must be requested within 60 days of employment.

(b) Payment may be issued prospectively, based on a billing statement or a detailed estimate of costs.

(3) Allowable costs: Allowable costs include, but are not limited to:

(a) special clothing, licensing and drug testing fees which an employer requires an employee to pay and which are a condition of employment;

(b) vehicle repairs, but not a vehicle purchase or insurance payment;

(c) tools which the employer requires an employee to pay for; or

(d) costs of bringing a home into compliance with certification requirements of the child care food program administered by CYFD, if the full cost is not available from the child care food program or CYFD.

(4) Costs not allowed: Costs associated with the start-up of a business or self-employment venture are not allowed. Such costs must be met through an IDA.

[8.102.620.15 NMAC - Rp 8.102.620.15 NMAC, 7/1/2024]

8.102.620.16 SUPPORTIVE SERVICES BENEFITS:

A. Issuance schedule: If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

(1) Participants assigned to a NMW activity may receive reimbursement on a monthly basis. Participants must submit participation reports to receive

the standard month's reimbursement, timely submission is required to receive the reimbursement. Reimbursement shall be authorized within five working days after receipt of all required verification. Support services shall be issued within 10 working days after authorization.

(2) Participants must submit the monthly participation report to be received no later than the fifth calendar day after a participation month's end. Reports received on the first workday after the fifth shall be considered timely if the fifth occurred on a weekend or holiday. Participants shall not be eligible to receive reimbursement if the report verifying participation is received 30 days or more following the end of the month for which participation is being reported.

B. Retroactive benefit coverage:

(1) Benefit coverage which provides supportive services may be issued retroactively to a participant if, upon individual case review, it is determined that:

(a) the participant was eligible to receive supportive services;

(b) the participant requested supportive services timely; and

(c) NMW staff inadvertently failed to process the reimbursements in a timely manner.

(2) NMW participants must have signed a WPA, which has been approved by the NMW service provider, which identifies the supportive services. Under no circumstances shall NMW participants be eligible to receive supportive service reimbursement for costs incurred prior to enrollment in the NMW.

[8.102.620.16 NMAC - Rp 8.102.620.16 NMAC, 7/1/2024]

8.102.620.17 SUPPORT SERVICES PAYEE: Supportive services reimbursements shall be made payable to the head of household for all travel and educational reimbursement.

[8.102.620.17 NMAC - Rp 8.102.620.17 NMAC, 7/1/2024]

HISTORY OF 8.102.620 NMAC:

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.620 NMAC Description of Program Benefits - Benefit Determination/General - Repealed, 07/01/2001.

8.102.620 NMAC - Description Of Program Benefits - Benefit Determination/General (filed 6/18/2001) - Repealed effective 7/1/2024.

Other: 8.102.620 NMAC - Description Of Program Benefits - Benefit Determination/General (filed 6/18/2001) Replaced by 8.102.620 NMAC - Description Of Program Benefits - Benefit Determination/General, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 110 GENERAL OPERATING POLICIES - APPLICATIONS

8.106.110.1 ISSUING AGENCY: New Mexico Health Care Authority.

[8.106.110.1 NMAC – Rp 8.106.110.1 NMAC, 7/1/2024]

8.106.110.2 SCOPE: The rule applies to the general public.

[8.106.110.2 NMAC - Rp 8.106.110.2 NMAC, 7/1/2024]

8.106.110.3 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.

[8.106.110.3 NMAC - Rp 8.106.110.3 NMAC, 7/1/2024]

8.106.110.4 DURATION: Permanent.

[8.106.110.4 NMAC - Rp 8.106.110.4 NMAC, 7/1/2024]

8.106.110.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.

[8.106.110.5 NMAC - Rp 8.106.110.5 NMAC, 7/1/2024]

8.106.110.6 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.

[8.106.110.6 NMAC - Rp 8.106.110.6 NMAC, 7/1/2024]

8.106.110.7 DEFINITIONS: [**RESERVED**]

[8.106.110.7 NMAC - Rp 8.106.110.7 NMAC, 7/1/2024]

8.106.110.8 GENERAL: The application shall be submitted on a form designated by the HCA either electronically or in writing and shall be made under oath by an applicant or an applicant on behalf of a dependent child who resides in the home. The application must contain a

statement of the age of the applicant or, dependent child, residence in New Mexico, all property in which the applicant has an interest, the income of the applicant or other benefit group members at the time the application is filed; the signature of the applicant, and other information required by the HCA.
[8.106.110.8 NMAC - Rp 8.106.110.8 NMAC, 7/1/2024]

8.106.110.9 RIGHT TO APPLY

A. An individual has the right to make a formal application for any cash, food or medical assistance program administered by the HCA, regardless of whether or not the individual appears to meet the conditions of eligibility. Any individual requesting information or assistance, or who wishes to apply for assistance, shall be encouraged to complete an application that same day.

B. An individual shall be informed of the right to apply, whether or not it appears the individual will be found eligible.

C. An individual shall be informed that the date of application affects the benefit amount for the first month of issuance.

D. Availability of applications: The HCA shall provide the YES-New Mexico web portal to submit the application online or paper applications for general assistance to anyone requesting an application and to local agencies and organizations that have regular contact with the public. Requests, written, electronic or by phone, for an application for assistance shall be provided with a mailed paper application or the YES-New Mexico web portal address to submit an online application.
[8.106.110.9 NMAC - Rp 8.106.110.9 NMAC, 7/1/2024]

8.106.110.10 THE APPLICATION:

A. Submission of an application: An application may be submitted to the HCA in person, by mail, via facsimile or by other electronic means which may include the YES-New Mexico web portal.

(1) Out-of-state applicants: An application received from out-of-state shall be accepted, but shall not be registered until the applicant contacts ISD to confirm their presence in the state. If the applicant does not contact the ISD within 30 days from receipt of the application, the application shall be returned to the applicant.

(2) Application for minor children: An application for assistance for minor children, including an un-emancipated pregnant minor, must be made by the adult with whom the child or children reside and who is assuming responsibility for the support and care of the child or children.

(a) If a pregnant minor is living in a second-chance home, maternity home or other adult-supervised supportive living arrangement, the application must be made by the supervising adult as the authorized representative for the minor pregnant woman.

(b) An emancipated minor may submit an application in the emancipated minor's own right.

B. Completeness of an application: To be accepted and registered, the cash assistance application, at a minimum, must identify the individual or individuals applying, the program(s) applied for, and must contain the signature of a responsible benefit group member, caretaker, authorized representative, or other legally responsible individual.

(1) The application form must be completed and signed by the applicant, the authorized representative or other responsible individual.

(2) If an authorized representative or another appropriate individual completes an application form on behalf of an applicant, the actual applicant must review and approve the completed form. The applicant is liable for improper payments resulting from erroneous information given by the authorized representative or other appropriate individual.

(3) The caseworker shall assist in completing the form if there is no other individual who can help the applicant. If an application is incomplete, ISD shall take action to notify the applicant. The individual who completed the application form must add the missing or incorrect information and initial and date the entries.

C. Application registration: A signed application shall be registered effective the date in which the application is received by the HCA during regular business hours; this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regular business hours or on weekends or holidays will be considered received as of the next business day.
[8.106.110.10 NMAC - Rp 8.106.110.10 NMAC, 7/1/2024]

8.106.110.11 INTERVIEWS:

A. Application interview:

(1) All applicants shall have a face to face interview.

(2) The interview may take place at a location reasonably accessible and agreeable to both the applicant and the caseworker.

(3) The applicant may bring any individual to the interview.

(4) The interview shall take place within 10 days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant.

B. Alternatives to an office interview: Waiver of the requirement that the interview be conducted in the ISD office shall be determined on a case-by-case basis for any individual who is unable to appoint an authorized representative, has no one able to accompany the applicant to the office because of transportation difficulties, or similar hardships that the county director determines warrants a waiver of the office interview. These hardship

conditions include, but are not limited to: illness, care of benefit group member, prolonged severe weather, or work hours which prevent an in-office interview during work hours. If an office interview is waived, the caseworker shall conduct a telephone interview or a home visit. Home visits shall be scheduled in advance with the benefit group as provided for at 8.100.180.17 NMAC. Waiver of the office interview, in and of itself, shall not be justification for extending the eligibility determination deadlines.

C. Scheduling an interview: An interview shall be scheduled upon receipt of the application. The interview shall take place within ten working days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant. Applications that are dropped off or submitted electronically after the close of business or on weekends or holidays will be considered received as of the next business day.

D. Missed interview: An applicant who fails to appear for the first interview shall be responsible for scheduling a second appointment for an interview. If the applicant does not contact the office or does not appear for a rescheduled interview, the application shall be denied on the 30th day (or the next workday if the 30th day is not a workday) after the application was filed.

E. Purpose and scope of interview: The interview is an official and confidential discussion of benefit group circumstances between the applicant and the caseworker.

(1) Prior to processing an application, there shall be a face-to-face interview with the applicant. The purpose and scope of the interview shall be explained to the applicant.

(2) The interview is intended to provide the applicant with information regarding eligibility requirements for the program and to provide the caseworker with the necessary information and documentation to make an accurate eligibility determination. In addition, the interview allows the caseworker to clarify unclear or incomplete information reported on the application.

F. Applicant information: During the course of the interview steps shall be taken to make the applicant feel at ease and protect the applicant's right to privacy. The interviewer shall inform the applicant about the following:

(1) the requirements that must be met by the applicant under the requested cash assistance program;

(2) responsibility to report changes;

(3) complaint and fair hearing procedures;

(4) application processing standards;

(5) procedures in cases of overpayment or underpayment of benefits;

(6) non-discrimination policies and procedures;

(7) timeliness standards.

[8.106.110.11 NMAC - Rp 8.106.110.11 NMAC, 7/1/2024]

8.106.110.12 APPLICATION PROCESSING TIME LIMITS:

A. Application processing time limit: The time limit begins on the day after the signed application is received by the ISD office.

(1) ARSCH program supplemental payments shall be processed no later than 30 calendar days after receipt.

(2) Set and variable term general assistance applications shall be processed no later than 90 calendar days, after receipt. Reconsideration determinations shall occur no later than 120 calendar days after receipt of the initial application.

B. Reconsideration: A reconsideration of a disability determination may be requested, verbally or in writing, by a client within 15 days of the date of the denial for not meeting conditions of disability. The reconsideration period shall not exceed 30 days from the date of denial. Disability will be evaluated based on additional medical evidence provided by the client during the reconsideration period. Should no request be made or the client does not provide additional medical evidence during the reconsideration period the denial shall remain and the client may reapply.

C. Delayed determination: If an eligibility determination is not made within the required application processing time limit due to HCA failure to assist the applicant or pursue eligibility timely, the applicant shall be notified in writing. The notice shall include the reason for the delay, and that the applicant has the right to request a fair hearing regarding the HCA's failure to act within the time limits.

[8.106.110.12 NMAC - Rp 8.106.110.12 NMAC, 7/1/2024]

8.106.110.13 DISPOSITION OF APPLICATION/NOTICE: Applicants shall receive written notice of application disposition, as indicated below:

A. Denials: Provide the reason for denial including regulation citation; the applicant's rights and time limits for requesting a fair hearing; and the applicant's right to discuss the denial with the caseworker, supervisor or county director.

B. Approvals: Inform the applicant who is eligible to receive benefits of the amount of payment and the certification period.

C. Withdrawal: An applicant may voluntarily withdraw the application orally or in writing any time before eligibility determination. Notice shall confirm the applicant's expressed desire to withdraw the application and be informed that the withdrawal does not affect the right to apply for assistance in the future.

[8.106.110.13 NMAC - Rp 8.106.110.13 NMAC, 7/1/2024]

8.106.110.14 APPROVAL EFFECTIVE DATE: General assistance benefits for an approved

application shall be effective the date of approval or from the 30th day after the date of application; whichever is earlier. Payment in the first month shall be prorated from the date of authorization.
[8.106.110.14 NMAC - Rp 8.106.110.14 NMAC, 7/1/2024]

8.106.110.15 CASE RECORD TRANSFERS: If a recipient moves to an area administered by another project area, the recipient's case record shall be transferred as follows:

A. Responsibilities of sending project area:

(1) The project area to which the recipient is moving or has moved to shall be notified within 10 days. The record shall not be transferred to the new project area until a new address for the recipient is provided to the sending project area.

(2) Before transferring the case record, the sending project area shall review the case record to ensure the information is complete and updated. The sending project area shall enter the recipient's new address and the geographic and administrative number in the computer system.

B. Responsibilities of receiving project area:

(1) The case is reviewed for changes and continued eligibility at the time of the transfer.

(2) The receiving project area shall transfer in the case by contacting the recipient to update the circumstances of the case and, at a minimum, document the benefit group's current circumstances. The receiving project area shall act on any change that becomes known by the sending project area, the recipient or any other means.

C. Transfer pending approval of an application: If transfer of a benefit group's case record is necessary before eligibility has been determined on an application, the sending project area shall transfer the pending application and associated documents to the receiving project area. The receiving project area shall continue the determination of eligibility based on the new circumstances. The application shall be completed based on the original application date.
[8.106.110.15 NMAC - Rp 8.106.110.15 NMAC, 7/1/2024]

8.106.110.16 APPLICATION MORATORIUM:

A. Based on limited state funds the HCA may limit the number of benefit groups by imposing a moratorium, subject to quarterly review, upon all GA applications. All applications for GA shall be denied under this provision without consideration of eligibility.

B. Program suspension: When state funds are unavailable the GA program may be suspended for a designated time period. GA payments will not be made to any benefit group and all rights to payment during the suspension period are lost. All applications for GA shall be denied without consideration of eligibility.

C. Notice: Notice shall be issued within 60 days, to all applicants denied due to moratorium or suspension in accordance and shall explain the applicant's right to discuss the denial with the caseworker, supervisor or county director.

(1) Notice to applicant: Applications denied based on a moratorium shall include the state statute and regulation, the date of denial, reason for denial, the regulation citation under which the denial was made, the applicant's right to a fair hearing, and the time limits for filing a fair hearing request.

(2) Public notice: The HCA shall issue a public notice 60 days prior to the imposition of a moratorium or suspension.

D. Interviews: GA applications denied on the basis of a moratorium or suspension shall not require an interview to meet the requirements specific to GA, other categories of assistance requested by the applicant may require an interview to determine eligibility.
[8.106.110.136 NMAC - Rp 8.106.110.16 NMAC, 7/1/2024]

History of 8.106.110 NMAC:
[**RESERVED**]

History of Repealed Material:
8.106.110 NMAC - General Operating Policies - Applications (filed 6/17/2004) effective, 7/1/2024.
Other: 8.106.110 NMAC - General Operating Policies - Applications (filed 6/17/2004) Replaced by 8.106.110 NMAC - General Operating Policies - Applications, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

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 ELIGIBLITY 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.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 230 GENERAL FINANCIAL - PAYABLES AND DISBURSEMENT

8.106.230.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.230.1 NMAC - Rp, 8.106.230.1 NMAC, 7/1/2024]

8.106.230.2 SCOPE: The rule applies to the general public.
[8.106.230.2 NMAC - Rp, 8.106.230.2 NMAC, 7/1/2024]

8.106.230.3 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.
[8.106.230.3 NMAC - Rp, 8.106.230.3 NMAC, 7/1/2024]

8.106.230.4 DURATION: Permanent.
[8.106.230.4 NMAC - Rp, 8.106.230.4 NMAC, 7/1/2024]

8.106.230.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.106.230.5 NMAC - Rp, 8.106.230.5 NMAC, 7/1/2024]

8.106.230.6 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.
[8.106.230.6 NMAC - Rp, 8.106.230.6 NMAC, 7/1/2024]

8.106.230.7 DEFINITIONS: [**RESERVED**]

8.106.230.8 PAYMENT ISSUANCE:

A. EBT: The HCA issues cash assistance benefits through an electronic benefit transfer (EBT) system.

B. Warrants: In some circumstances a payment can be issued by warrant.

C. Death of a recipient: An authorized beneficiary may access and use payments issued on behalf of a recipient who died before an EBT withdrawal was made if the recipient:

(1) was alive on the first day of the month for which cash assistance benefits were issued; and

(2) met all eligibility conditions at the time of death.
[8.106.230.8 NMAC - Rp, 8.106.120.8 & 9 NMAC, 7/1/2024]

HISTORY OF 8.106.230 NMAC:

History of Repealed Material:
8.106.230 NMAC, General Financial -Payables and Disbursement, filed 06/17/2004 - Repealed 12/01/2009.
8.106.230 NMAC - General Financial - Payables And Disbursement (filed 11/17/2009) - Repealed 7/1/2024.

Other: 8.106.230 NMAC - General Financial - Payables And Disbursement (filed 11/17/2009) Replaced by 8.106.230 NMAC - General Financial - Payables And Disbursement, effective 7/1/2024.

HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 110 GENERAL OPERATING POLICIES APPLICATIONS

8.119.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.110.1 NMAC - Rp, 8.119.110.1 NMAC, 7/1/2024]

8.119.110.2 SCOPE: The rule applies to the general public.
[8.119.110.2 NMAC - Rp, 8.119.110.2 NMAC, 7/1/2024]

8.119.110.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal authority from time to time.

B. In accordance with authority granted to the health care authority by Subsection J of Section 27-1-3 NMSA 1978 and pursuant to Executive Order No. 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. 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.
[8.119.110.3 NMAC - Rp, 8.119.110.3 NMAC, 7/1/2024]

8.119.110.4 DURATION: Permanent.
[8.119.110.4 NMAC - Rp, 8.119.110.4 NMAC, 7/1/2024]

8.119.110.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.119.110.5 NMAC - Rp, 8.119.110.5 NMAC, 7/1/2024]

8.119.110.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. The HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.110.6 NMAC - Rp, 8.119.110.6 NMAC, 7/1/2024]

8.119.110.7 DEFINITIONS: [**RESERVED**]
[8.119.110.7 NMAC - Rp, 8.119.110.7 NMAC, 7/1/2024]

8.119.110.8 APPLICATIONS:

A. Processing applications: Application processing requirements, timeliness and verification standards, procedures, forms, and notification requirements established for the NMW program are applicable to the RRP, unless otherwise noted.

B. If there are children 19 and under included in the household, the applicant's eligibility will first be determined in accordance with all NMW program requirements, procedures and policies. If the applicant is not found eligible for NMW, eligibility shall then be determined under the RRP.

C. Refugees are not required to apply for cash assistance in order to apply for medical assistance.

D. For cash assistance applicants, only those sections of the form dealing with the following information must be completed:

(1) identification and origin of the refugee applicants;

(2) income and resources of the benefit group;

(3) living arrangements; and

(4) statement of agreement and understanding of the circumstances under which cash assistance is granted, signed by the applicant.

E. If an otherwise eligible refugee demonstrates an urgent and immediate need for cash assistance, the application will be processed with due diligence to expedite the initial RCA payment on an emergency basis.
[8.119.110.8 NMAC - Rp, 8.119.110.8 NMAC, 7/1/2024]

8.119.110.9 REFERRAL TO OTHER AGENCIES:

A. Referral to sponsoring agency: The county office is required to notify the refugee's sponsor or local affiliate which provided for the resettlement of the refugee whenever a refugee applies for RCA. This requirement applies to new arrival refugees and to second migration refugee cases. In the event the VOLAG does not have a local affiliate for the latter cases, the VOLAG will be notified. A response from the sponsor is not required and workers should not delay an application for this reason. A current list of VOLAGs is available on the ORR website.

B. Referral to SSI:

(1) All refugee applicants and recipients who are 65 years of age or older, or who are blind or disabled, will immediately be referred by the county office to the social security administration to apply for SSI benefits.

(2) Such refugees will be included in the assistance grant, using the NMW standard of need until SSI benefits take effect. Refugees are advised to report SSI payments when received, to ISD.
[8.119.110.9 NMAC - Rp, 8.119.110.9 NMAC, 7/1/2024]

History of 8.119.110 NMAC: