State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

VELVET G. MILLER
Director

MEDICAID COMMUNICATION NO. 95-16 **DATE:** November 9, 1995

TO: County Welfare Agencies
ISS Area Offices

SUBJECT: Change in Minimum Age for Estate Recoveries

In accordance with the Federal Omnibus Budget Reconciliation Act of 1993, the Medicaid program is required to recover correctly paid benefits from the estates of deceased beneficiaries who received medical assistance at age 55 or older. Prior to that change, the minimum age for such recoveries was age 65.

This change was effective for all estates that come into being on and after April 1, 1995 and should be implemented immediately. Accordingly, please communicate the requirement to all applicants at the time of application and to all beneficiaries at the time of redetermination. To assist in that effort, the authorization page (Page 7) of the revised PA-1G incorporates the new age requirement. In addition, note that two other changes have been made to the authorization page. The requirement to provide a Social Security Number has been added and the requirement to notarize the form has been deleted.

The revised PA-1G has been completed and will be communicated to you under separate cover. Until the new PA-1G is available, please use the revised authorization page with the existing PA-1G in lieu of the obsolete (Rev. 1/94) version.

Questions concerning the new minimum age for estate recovery or estate recovery in general should be directed to the Division's Bureau of Administrative Control, CN-712, Mail Code #6, Trenton, New Jersey 08625-0712, telephone (609) 588-2900. Questions concerning this form as it relates to the Medicaid application process should be directed to your field service representative.

Sincerely,

Velvet G. Miller
Director

VGM:Pp
Attachment
cc: Karen Highsmith, Acting Director
Division of Family Development
Patricia Balasco-Barr, Director
Division of Youth and Family Services

BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE ASK

*I (We) agree that the statements made on this form are true and complete to the best of my (our) knowledge. I (We) know that lying about my (our) situation, failing to give necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution.

*I (We) understand that any information (We) give is subject to verification by the County Welfare Agency (CWA) and/or other agencies or officers of the Division of Family Development (DFD) and the Division of Medical Assistance and Health Services (DMAHS).

*I (We) hereby authorize the County Welfare Agency, Division of Family Development, and/or the Division of Medical Assistance and Health Services to contact any individual or other source who may have knowledge about my (our) circumstances (to include IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, and/or credit reporting services), for the sole purpose of verifying the statements I (We) have made.

*I (We) know that any information I (We) give will be used only in connection with my (our) application for public assistance and receipt of Medicaid benefits.

*I (We) understand that Medicaid benefits received after age 55 may be reimbursable to the State of New Jersey from my estate.

*I (We) agree to let the CWA, DFD, and/or the DMAHS know immediately, of any change in living arrangements, family situation or money received from any source. If disabled, I (We) agree to report any improvement in my (our) medical condition.

*I (We) understand that as a condition of eligibility for medical assistance, it is deemed that I (We) have assigned to the Commissioner of Human Services, any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.

*I (We) understand that I (We) may request a fair hearing, if I (We) am (are) not satisfied with any action taken by the CWA, DFD, or DMAHS.

*I (We) understand that I (We) will not be discriminated against because of race, color, religion, sex, handicap, national origin or marital, parental or birth status.

*I (We), by signing below, attest that I (We) have read and agree to these statements and fully realize that the County Welfare Agency and/or the Division of Family Development and/or the Division of Medical Assistance and Health Services rely upon the truth and accuracy of my (our) statements.

SIGNATURES

Applicant _____ Date _____

Spouse _____ Date _____

Authorized Agent _____ Date _____

Relationship to Client _____

Address _____

_____

NOTE: The submission of a Social Security Number (SSN) is mandatory in accordance with 42 USC 1320b-7. Your SSN will be used to check your identity, prevent duplicate participation and facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits and to make sure you are eligible for Medicaid. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Medicaid programs. Such persons may be subjected to criminal action, administrative claims and/or possible loss of all benefits. Failure to file for a SSN may result in disqualification for Medicaid.