REIMBURSEMENT AGREEMENT AND ACKNOWLEDGMENT

Applicant Name: _____ Spouse: _____
(Please print) (Please print)

Address: _____ County: _____

FINANCIAL ASSISTANCE APPLICANTS

I, _____ and _____ ,
understand that N.H. State Laws, RSA 167:13, RSA 167:14, RSA 167:14-a, and RSA 167:28, require reimbursement to the State and County from me or my spouse for the financial assistance provided, as a condition of eligibility for the APTD, ANB, and OAA Programs.

I UNDERSTAND THAT: **INITIALS**

- a notice of lien may be filed against any real property owned by me or my spouse, severally or jointly, at any time after financial assistance begins and that the State shall not seek collection on such a lien so long as my spouse or I reside on the property as the lawful owners, unless the property is voluntarily sold or refinanced while a lien is in place. _____
- a claim may be filed against my or my spouse's estate to satisfy the State's claim for reimbursement of financial assistance granted. _____
- if the State intends to file a notice of lien on my real property, written notification will be sent to me and I will have the opportunity to appeal the lien placement. _____
- the State also has the right to recover the cost of medical assistance (Medicaid) payments made on my behalf, as described on page two (2) of this form. _____
- failure to sign this form will result in ineligibility for financial assistance in accordance with RSA 167:28. _____

☐ I have read and understand my rights and responsibilities as explained on this Form and have had the opportunity to ask questions about this information.

Dated at _____ this _____ day of _____ , _____
(Place) (Date) (Month) (Year)

_____ _____
Signature of Applicant/Parent Signature of Spouse/Parent

The State of New Hampshire

_____ ss.

Personally appeared the above named _____

and _____ and acknowledged the foregoing document to be their voluntary act and deed.

Before me,

_____ _____
(Month/Day) (Year)

Justice of the Peace or Notary Public

POLICIES APPLYING TO ALL MEDICAL ASSISTANCE (MEDICAID) APPLICANTS

Applicant Name: _____ Spouse _____
(Please print) (Please print)

Address: _____ County: _____

I UNDERSTAND THAT: **INITIALS** (Optional)

- under Federal and State law, I may be required to reimburse the government for the cost of Medicaid payments made on my behalf under OAA, ANB, MEAD, BCCP, or APTD while I am age 55 or older, and that the State may file a lien against my real property and/or file a claim against my estate to recover Medicaid costs. _____
- pursuant to State and Federal Law, the State will not seek recovery from my estate until or unless my spouse, if any, has died and I have no child who is under age 21 or who is blind or permanently and totally disabled. _____
- only assets contained in my estate will be available for recovery for the medical assistance provided to me. _____
- for the purpose of recovery of medical assistance provided to me, my "estate" includes both assets that pass through probate and assets that pass outside the probate process such as certain trust assets, assets held jointly, and unpaid annuity balances benefiting me. _____
- under state law my estate includes all property real or personal, in which I hold an interest on the date of my death. Such interests include joint tenancy with rights of survivorship, tenancy in common, life estates, and living trusts without regard to the date that such title or interest was established. _____
- if I hold property as a joint tenant with right of survivorship or hold a life estate at the time of my death, the State will provide written notice of the State's claim to the surviving owner(s). _____
- when recovery action begins, the State will notify the executor of my estate of the reimbursement claim and, pursuant to He-W 895, the availability of a waiver if recovery would cause an undue hardship to my heirs. _____

POLICIES APPLYING TO PERMANENT RESIDENTS OF MEDICAL INSTITUTIONS:

In addition to the reimbursement responsibilities described above, the following applies to individuals permanently residing in medical institutions who receive Medicaid payments for the cost of institutional care.

I UNDERSTAND THAT: **INITIALS** (Optional)

- if it is determined that I cannot reasonably be expected to be discharged from a medical institution, the State will file a lien against real property I own, including my home, unless any of the following individuals resides in my home:
  - My spouse;
  - My child who is under age 21, or who is blind or permanently and totally disabled; or
  - My sibling who has an equity interest in the home and who was residing in the home for at least one year prior to my admission to the medical institution. _____
- if the State intends to file a lien on my real property, written notification will be sent to me and any other joint owner(s) and I will have an opportunity to appeal the lien placement. _____
- any lien placed on my home will be removed upon my discharge from a medical institution. _____

☐ I have read and understand my rights and responsibilities as explained on this Form and have had the opportunity to ask questions about this information.

_____ _____
(Optional) Signature of Applicant/Parent (Optional) Signature of Spouse/Parent

_____ _____
Family Services Specialist Date

Return to: Centralized Scanning Unit (CSU), P.O. Box 181, Concord, NH 03301