ADMINISTRATION FOR
CHILDREN & FAMILIES

Administration for
Children & Families

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FEB 0 4 2015

Sidonie Squier
Secretary
New Mexico Human Services Department
Pollon Plaza
P.O. Box 2348
Santa Fe, NM 87504-2348

Dear Ms. Squier,

We are pleased to inform you that the fiscal year 2015 State Plan for the New Mexico Refugee Resettlement Program is approved. Based on our review, your State Plan is in compliance with the Office of Refugee Resettlement (ORR) regulations at 45 CFR Part 400.

This State Plan approval authorizes the Refugee Medical Assistance (RMA) program to provide medical screenings conducted in accordance with 45 CFR 400.107. Per 45 CFR 400.107(b), a screening conducted during the first 90 days *may* be provided without prior determination of the refugee's eligibility for Medicaid. However, ORR expects that medical screening services covered under Medicaid and other sources will be billed to Medicaid or those other sources when possible. If screening is necessary after 90 days, States must ensure RMA is only accessed when a refugee is determined ineligible for Medicaid. We would like to reiterate that screenings should strive for conformity with ORR's guidelines as detailed in State Letter 12-09.

To ensure equal and timely access to Medicaid, States should be in full compliance with State Letter 13-10.

We appreciate the work of your office to successfully resettle refugees in New Mexico and we look forward to continuing our partnership with the New Mexico Refugee Resettlement Program.

If you have any questions pertaining to this approval letter, please contact your Regional Representative or Carl Rubenstein, Acting Director, Division of Refugee Assistance, by phone at (202) 205- 5933 or by email at carl.rubenstein@acf.hhs.gov.

Sincerely,

Kenneth Tota
Acting Director
Office of Refugee Resettlement

Refugee Resettlement Program
State Plan – FY 2015

HUMAN SERVICES
DEPARTMENT

State of New Mexico
Human Services Department

Susana Martinez
Governor

Sidonie Squier
Secretary

Prepared By: Kresta-Leigh Opperman
State Refugee Coordinator

State of New Mexico
Human Services Department

Refugee Resettlement Program
State Plan – FY 2015

As per Title 8, Chapter 119, Part 110, Paragraph 3B (8.119.110.3B) of the New Mexico Administrative Code (NMAC) and Executive Order 80-62 the New Mexico Human Services Department (HSD) has been designated as the single state agency responsible for administering the refugee resettlement program. Within HSD, the administration of the program is vested in the Refugee Resettlement Program within the Work and Family Support Bureau (WFSB) of the Income Support Division (ISD).

The Refugee Resettlement Program, through the State Coordinator, is responsible for coordinating all aspects of ISD services to refugees, including the provision of cash and medical assistance and the monitoring of the activities of all HSD contractors serving refugees in the furtherance of the State Plan. Kresta-Leigh Opperman is the State Refugee Coordinator for New Mexico.

Approved:

Sidonie Squier 10/23/14

Secretary
New Mexico Human Services Department

Refugee Resettlement Program State Plan

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ADMINISTRATION

1. PURPOSE

The purpose of the New Mexico Refugee Resettlement Program (RRP) is to ensure the effective resettlement of refugees in the State of New Mexico through programs designed to meet one or more of the State's three major goals:

A. To provide for the effective resettlement of refugees within the shortest possible time after entrance into the State using coordinated supportive services. Effective resettlement means the refugee's ability to access community resources to meet his or her basic needs related to employment, English Language Training (ELT), skills training, medical care, and social and cultural adjustments.

B. To promote economic self-sufficiency for refugees within the shortest possible time after entrance into the State through employment and acculturation by the coordinated use of financial, medical, and supportive services. Economic self-sufficiency is gainful employment in:

1) a non-subsidized job for at least 90-days; and

2) receipt of a minimum wage; and

3) a job that provides for basic economic needs of the person and family without reliance on public assistance.

C. To protect the refugees and the community from infectious disease and health related issues during resettlement

2. DESIGNATED STATE AGENCY

The Governor has designated the New Mexico Human Services Department (HSD) as the State agency responsible for the administration and operation of the New Mexico RRP. The Secretary of HSD has assigned program responsibility to the Income Support Division (ISD) [45 CFR §400.5(a)].

3. APPOINTMENT OF STATE COORDINATOR

Kresta-Leigh Opperman was designated by the State of New Mexico HSD as the State Refugee Coordinator (SRC) as of July 11, 2011 [45 CFR §400.5(d)].

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Work and Family Support Bureau
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4. STATE INTERNAL FISCAL CONTROL PROCEDURE

A. Fiscal control procedures, utilizing Generally Accepted Accounting Practices (GAAP), are employed to record and monitor all expenditures whether funds are allocated through the department for direct services or through contracted services.

B. HSD's Administrative Services Division (ASD) provides all estimates and RRP expenditure reports.

C. ASD reviews all contracts and expenditures. The ASD Grants Management Bureau and the New Mexico Department of Finance and Administration's Audit Bureau provide audits of funding and expenditures. Independent audits are required of all service contractors. The State Refugee Coordinator reviews and approves all contract expenditures prior to payment. ASD makes final authorization for payment after reviewing the invoice.

5. TECHNICAL ASSISTANCE AND TRAINING

The State Refugee Coordinator, through regular communication including telephone, e-mail, on-site visits, and regularly scheduled meetings, provides program information and technical assistance to contractors, ISD staff, and other agencies.

6. CONSULTATION BODIES

The New Mexico Refugee Program Advisory Committee (NMRPAC) serves as the planning and coordinating body required in 45 CFR §400.5(h). NMRPAC is composed of representatives from the agencies providing service to refugees; ISD, Catholic Charities, Lutheran Family Services, and the Department of Health. NMRPAC meetings will be held quarterly in Albuquerque and serve as an advisor to the SRC and refugee service providers.

7. ASSURANCES

The State of New Mexico assures that all applicable requirements of 45 CFR 400 and 45 CFR 401 will be met [45 CFR §400.5(i) (2)]. This includes compliance with;

A. The provisions of Title IV, Chapter 2, of the Immigration and Nationality Act [45 CFR §400.5(i)(1)] and official issuances of the Director of the Office of Refugee Resettlement (ORR), hereafter referred as the Director [45 CFR §400.5(i)(1)];

B. All applicable Federal statutes and regulations in effect during the time that the State is receiving grant funding [45 CFR §400.5(i)(3)];

C. The requirements to amend the state plan as needed to comply with standards, goals, and priorities as established by the Director [45 CFR §400.5(i)(4)];

D. The requirement, as specified under 45 CFR §400.145(c), that refugee women have the same opportunities as refugee men to participate in all ORR funded services;

E. The requirement, as specified under 45 CFR §400.5(g), that assistance and services funded under the State plan will be provided to refugees without regard to race, religion, sex, national origin, disability, and/or political opinion;

F. The requirement, as specified under 45 CFR §400.5(h), that, unless exempted from this requirement by the Director, meetings will be convened, at least quarterly, with representatives of local refugee resettlement agencies, local community service agencies, and state agencies and local governments. The purpose of these meetings is to plan and coordinate the placement of refugees in advance of their arrival.

G. The requirement that the State will use the same mediation/conciliation procedures that are used in the State Temporary Assistance for Needy Families (TANF) program; and

H. The requirements that the State provide refugees with access to a hearing to contest adverse eligibility determinations, provide timely notice of hearings and use the hearing standards and procedures as set forth in 45 CFR §400.23, 45 CFR §400.54 and 45 CFR §400.83(b).

8. EFFECTIVE DATE

The effective date of this State of New Mexico RRP Plan is October 1, 2014.

ORGANIZATION AND COORDINATION OF EFFORT

Consistent with the intent of the ORR, HSD has established a network of relationships within government and community organizations that seek to coordinate public and private efforts on behalf of refugees and to maximize the impact of services made available to refugees through the RRP.

1. WITHIN THE HUMAN SERVICES DEPARTMENT

The New Mexico RRP is administered within the ISD of the New Mexico HSD, a Governor's Cabinet level Department. ISD coordinates the State's efforts in assisting refugees to achieve the earliest possible economic self-sufficiency through employment by facilitating access to required services and supports. The administrative structure of HSD is represented by the HSD Organization Chart. See attachment 1.

ISD field offices are charged with providing eligibility processing for Temporary Assistance for Needy Families (TANF), Medicaid, Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program, the Low Income Home Energy Assistance Program (LIHEAP) and other public benefits as well as the Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) programs. This places ISD in a unique position to create and foster an environment in which refugees are able to access services they require during their initial resettlement period, have their participation monitored, and resolve issues that could lead to a disruption in the resettlement process.

The RRP utilizes the resources of a number of HSD divisions and bureaus to administer and manage the RRP:

A. The Grants Management Bureau within ASD provides ISD with grant management and fiscal reporting support.

B. The Financial Accounting Bureau within ASD tracks all RRP expenditures and ensures the accuracy of fiscal reports.

C. The Contract Management Bureau within ASD assists in the development of contracts for the delivery of refugee social services.

D. The Budget Bureau within ASD assists the RRP with budget projections and cost estimates.

E. HSD's Office of General Counsel (OGC) helps to ensure that the policies and regulations proposed by ISD are consistent with the laws and regulations of the State of New Mexico and the United States Government.

F. The Client Services Bureau in the Medical Assistance Division (MAD) develops Medicaid policy and medical service delivery procedures and regulations.

G. The Policy and Program Development Bureau within ISD develops policies, procedures and regulations with respect to the delivery of TANF, SNAP, LIHEAP, RCA, and RMA.

H. The Information Technology Division (ITD) within HSD manages the hardware and software used by ISD to administer the RRP.

I. The Hearings Bureau within HSD's Office of Inspector General (OIG) establishes the rules for conducting fair hearings.

J. The OIG Internal Audit Bureau conducts internal audits.

2. BETWEEN HSD AND OTHER NEW MEXICO STATE DEPARTMENT, LOCAL GOVERNMENTS, AND AGENCIES

HSD has developed a relationship with other departments within State and local government to facilitate the objectives of the RRP:

A. New Mexico Department of Health (DOH) works closely with HSD to accomplish timely refugee health screenings, to disseminate health education materials within refugee communities, and to develop plans in response to health emergencies that may affect refugees in the State of New Mexico;

B. The Children, Youth and Families Department (CYFD) provides childcare services;

C. The Aging and Long Term Services Department (ALTSD) makes available supportive services that enhance independence to older refugees. Such services may include Meals-on-Wheels, mentoring and transportation assistance;

D. The New Mexico Department of Work Force Solutions (DWFS) provides employment and training services;

E. Albuquerque Public Schools work closely with the local resettlement agencies in the placement and progress of refugee children enrolled in public school as well as with the provision of pre and post school hour childcare services; and

F. Local governments, particularly the City of Albuquerque, consult with both ISD and the local resettlement agencies regarding refugee placement issues so that the profiles of the refugees placed in the area are matched to available resources.

3. BETWEEN HSD AND LOCAL SERVICE PROVIDERS

HSD works with the local resettlement agencies to facilitate the coordination of services as funded by ORR. As part of this coordination, the local resettlement agencies work with newly arrived refugees during the first few days after arrival in New Mexico to develop an Individual Resettlement Plan (IRP), which includes the refugee's Individual Employment Plan (IEP). The local resettlement agencies then assist refugees to enroll in the services identified in his or her plan.

The local resettlement agencies assist the refugee to navigate the enrollment process for RCA and RMA programs, which are administered through ISD. As required in 45 CFR§ 400.75, a referral to RCA is always coupled with a referral to the Refugee Employment Services Program administered through the local resettlement agencies. In some instances the applicant may be exempt from this requirement as described in the Financial Assistance section of this State Plan.

HSD works with the local resettlement agencies and other local service providers to enhance the level of coordination, scope, and quality of services made available to refugees served through the RRP. These efforts include assistance with securing funding for services, identifying weaknesses, and/or gaps in service, training, and program monitoring.

4. MUTUAL ASSISTANCE ASSOCIATIONS AND ETHNIC COMMUNITY-BASED ORGANIZATIONS

A focus of the State RRP is to encourage the formation of Refugee Mutual Assistance Associations (MAAs) and Ethnic Community-Based Organizations (ECBOs) to provide a wide range of supportive services to the local refugee community. A consensus between professional service providers and volunteer organizations suggests that without the growing involvement of refugees themselves in the provision of culturally and linguistically appropriate services for refugees will not be as effective. The State will assist in the development of MAAs and ECBO's and encourage them to:

A. Identify and assess refugee populations and needs in high impact areas, particularly the unemployed and illiterate refugee; provide counseling and make referrals to HSD, ELT Projects and any other appropriate agencies. Provide follow-up support to service agencies;

B. Provide supplemental orientation programs to newly arrived, secondary migrant refugees, and the general refugee population in cooperation with HSD and the local refugee resettlement agencies; and

C. Assist refugee workers in providing interpretation services to existing mental health agencies to serve the mental health needs of the refugee population.

5. SPECIFIC STATE REFUGEE COORDINATOR RESPONSIBILITIES

The SRC is responsible for the administration of the ORR funded portion of the RRP and performs the following functions under the direction of the ISD Work and Family Support Bureau (WFSB) Chief:

A. Write the New Mexico Refugee Resettlement State Plan, and amend the plan, as needed [45 CFR §400.4];

B. Coordinate with ASD in the development of annual budget requests and quarterly budget revisions, as needed;

C. Oversee the development of Professional Service Contracts and General Services Agreements with local agencies and monitor the effectiveness of these contracts to ensure compliance with federal regulations;

D. Develop State RRP policy in coordination with ISD's Policy and Program Development Bureau and monitor programs to ensure compliance with state and federal regulations;

E. Assist MAD in developing appropriate policies and procedures for the provision of medical assistance to refugees and monitor the RMA program to ensure compliance with all federal regulations;

F. Facilitate the coordination of services and activities on behalf of refugees by State and local refugee service providers and community organizations as described in the New Mexico Refugee Resettlement State Plan;

G. Serve as the convener and administrator of the NMRPAC;

H. Act as the State contact to federal, regional and national refugee organizations; and

I. Provide public relations to enhance effective refugee resettlement in the State.

FINANCIAL ASSISTANCE

1. REFUGEE CASH ASSISTANCE

The State of New Mexico takes the option to provide a publicly administered RCA program as provided in 45 CFR §400.65 through 45 CFR §400.68.

The RCA program is administered by the HSD. HSD is also the State's TANF agency. The State's TANF cash assistance program is called New Mexico Works (NMW).

A. Coordination of Services

The provision of RCA is coordinated with the provision of other supportive services to facilitate an effective refugee resettlement process leading to the earliest possible employment and economic self-sufficiency. The local resettlement agencies begin by working with the refugee to develop an IRP. If RCA is called for, in the IRP the refugee's local resettlement agency will assist the refugee with the application process. The local resettlement agencies are responsible for monitoring progress and compliance with all aspects of the IRP and for modifying the plan as progress and circumstances warrant. HSD is responsible for monitoring the resettlement agencies' activity in this regard.

B. Eligibility

Eligibility for RCA is limited to those applicants who are able to provide documentation, issued by the United States Customs and Immigration Service (USCIS) of having or having held one of the defined refugee statuses as defined in 45 CFR §400.43. RCA is time limited to the first eight months from the date of the refugee's lawful admission into the United States.

An applicant for asylum is not eligible for RCA assistance unless otherwise provided by Federal Law [45 CFR §400.44]. Any national of Cuba or Haiti who has an application for asylum pending with the U.S. Department of Homeland Security (DHS) and a final non-appealable and legally enforceable Order of Removal has not been entered, is eligible for RCA for a period of no more than eight months from the date of entry [Public Law 96-422].

1) Determination of Eligibility under other programs:

   a) Refugees applying for financial assistance must establish eligibility in the following priority [45 CFR §400.51]:

      (1) The NMW program is the first choice; and

(2) The RCA program is the secondary choice.

b) If there is a minor dependent in the family unit, the refugee family may qualify under the NMW program. RCA is for adults without minor children. Refugees applying for NMW must meet the same eligibility criteria as other non-refugee applicants with the exception of citizenship and enumeration.

c) Refugees who are 65 years of age or older, or who are blind or disabled shall be referred to the Social Security Administration (SSA) to apply for cash assistance under the Supplemental Security Income (SSI) program [45 CFR §400.51(b)(1)(i)]. Refugees who are 65 years of age or older, or who are blind or disabled, and have been determined eligible for NMW or RCA shall be provided financial assistance until eligibility for SSI is determined, provided the conditions of eligibility for NMW or RCA continue to be met [45 CFR §400.51(b)(1)(ii)].

d) The State shall promptly notify the local resettlement agency that provided for the initial resettlement of a refugee whenever the refugee applies for RCA [45 CFR §400.68(a)].

(1) Such notification may be made verbally to the resettlement agency representative assisting the refugee in their application for assistance.

(2) If the refugee applies for financial assistance without the assistance of a local resettlement agency, the State shall contact the refugee's local resettlement agency before processing the application to advise the agency of the refugee's intent to apply for financial assistance.

2) Eligibility for RCA is limited to those refugees who [45 CFR §400.53]:

a) are new arrivals who have not resided in the U.S. for more than eight (8) months; and

b) are determined ineligible for NMW or SSI ; and

c) meet the immigration status and identification requirements establishing refugee status; and

d) are not full-time students of higher education; and

e) meet the income eligibility standard established by the State.

3) Complete and signed applications shall be registered effective the date on which the application is received. Upon completion of the interview and receipt of required

documentation the RCA application shall be processed. If RCA is approved the benefit start date shall be the date of application [45 CFR §400.66(e)].

4) The eligibility process for RCA shall be the same as for NMW and other State operated financial assistance programs [45 CFR §400.66(a)]. This includes the following:

   a) the determination of initial and on-going eligibility; and

   b) the budgeting methods, including gross income, net income, and standard needs budget; and

   c) the treatment of income, assets and resources, including disregards; and

   d) the treatment of shelter, utilities and similar needs; and

   e) the determination of benefit amounts.

5) Refugee specific eligibility criteria:

   a) HSD may not consider any cash grant received by the refugee under the Department of State's or Department of Justice's Reception and Placement Programs in determining eligibility [45 CFR §400.66(d)];

   b) HSD may not consider any resources remaining in the refugee's country of origin in determining eligibility [45 CFR §400.66(b)];

   c) HSD may not consider a sponsor's income and resources to be accessible to the refugee solely because the person is serving as a sponsor [45 CFR §400.66(c)];

   d) HSD shall contact the refugee's local resettlement agency concerning offers of employment and to inquire whether the applicant has voluntarily quit employment or has refused to accept an offer of employment within 30 consecutive days immediately prior to the date of application [45 CFR §400.68(b)]; and;

   e) HSD may grant exemptions from the employment registration and participation requirements of eligibility for RCA in accordance with the New Mexico Administrative Code (NMAC) 8.119.410.11E.

C. Emergency RCA Issuance

If an otherwise eligible refugee demonstrates an urgent and immediate need for financial assistance, the application will be processed with due diligence to expedite the initial RCA payment on an emergency basis [45 CFR §400.52].

D. Participation in the Refugee Employment Program

As a condition for receipt of RCA, an employable refugee must participate in the Refugee Employment Program as provided for under the Refugee Social Services section below [45 CFR §400.75(a)].

E. Sanction Procedures for Failure to Participate in the Refugee Employment Program

Unless determined exempt, in accordance with NMAC 8.119.410.11E, refugees are considered employable. When an employable refugee fails or refuses to comply with the requirements for work and training this individual will be considered to be in non-compliance and the following sanction procedure will be applied:

1) The Refugee Employment Services contractor(s) will provide counseling within seven days of notification to ensure the refugee understands the requirements for work and training and the effects of non-compliance.

2) If the employable refugee recipient continues to remain in non-compliance, the client will be sanctioned 30 days after the initial date of non-compliance. This sanction will be applied as follows:

   a) A Notice of Adverse Action will be issued to the client and benefits will not be reduced or terminated until 13 days from the date on the adverse action notice.

   b) The refugee's sponsor or the local resettlement agency shall be notified of the intended adverse action.

   c) If the refugee regains compliance within 30-days after the initial date of non-compliance, benefits will continue without interruption.

   d) If the employable refugee recipient remains in non-compliance he or she will be disqualified from financial assistance for a period of three months after the first occurrence. A second occurrence will result in disqualification from financial assistance for a period of six months. [45 CFR §400.82(c) (2)].

3) SNAP and medical assistance may be continued to the sanctioned refugee, provided the sanctioned refugee continues to meet the eligibility requirements of each program.

F. Notice of Department Action [45 CFR §400.54 and 45 CFR §400.82]

1) A recipient of RCA shall be sent, or provided, a written Notice of Adverse Action when benefits are reduced, suspend, or terminated. This notice will be provided at least 13 days prior to the effective date of the action. The written notice will clearly

state the intended adverse action to be taken, the reasons for the action, and the right to request a fair hearing. The notice of adverse action will be written in English and translated by a designee of HSD, either in writing or verbally, in the native language of the refugee to ensure the content of the notice is effectively communicated to the refugee.

2) When a recipient of RCA is notified of terminated benefits due to having reached the time limit, the case must be reviewed to determine if circumstances have changed such that the recipient may be eligible for NMW or General Assistance (GA).

3) If the department action involves an overpayment, the overpayment will be referred to the Restitution Bureau of the HSD Office of Inspector General.

G. Hearings to Contest Adverse Department Actions

1) An applicant for, or a recipient of, RCA who receives an adverse eligibility determination shall be entitled to a fair hearing to contest the adverse action. Such hearings will be conducted in accordance with the procedures as outlined in the New Mexico Administrative Code (NMAC) Program Participation Hearings section.

2) If adverse determination is based upon the refugee's date of entry into the United States, and the date of entry is in question, then the local resettlement agency responsible for the initial resettlement of the refugee shall review the individual's immigration documentation, as provided by USCIS. The resettlement agency shall provide HSD with verification of the individual's correct date of entry into the US.

2. GENERAL ASSISTANCE PROGRAM

A refugee who has been in the U.S. longer than 8 months, is disabled, and is not eligible for NMW, shall be evaluated for State General Assistance (GA). The same policy and procedures will be followed as for all other GA applicants with the exception of the requirement for citizenship and enumeration.

GA provides temporary cash assistance to adults without minor children who are determined by IRU to have a physical or mental health disability that prevents the individual from engaging in employment or training. IRU also determines, based on the medical documentation provided, the length of time a person may receive GA before the individual's ability to engage in employment or training must be reevaluated. For this reason an individual may receive GA for a temporary condition or may receive GA for a permanent condition while they are in the process of applying for SSI.

MEDICAL ASSISTANCE

1. REFUGEE MEDICAL ASSISTANCE

RMA is administered by HSD.

2. COORDINATION OF SERVICES

The provision of RMA is coordinated with the provision of other supportive services to facilitate an effective refugee resettlement process leading to the earliest possible employment and economic self-sufficiency. This coordination begins in the local resettlement agencies with the development of an IRP between the refugee and the agency. The resettlement agencies also assist the refugee with the RMA application process, if RMA is called for in the IRP. The local resettlement agencies are responsible for monitoring progress and compliance with all aspects of the IRP and for modifying the plan as progress and circumstances warrant. The HSD is responsible for monitoring the resettlement agencies' activity in this regard.

A. Eligibility

RMA is time limited to the first eight months from the refugee's date of arrival into the United States or, for asylees, eight months from the date of the Grant of Asylum.

All refugees wishing to do so will be provided with an opportunity to apply for medical assistance and the State will determine the eligibility of each applicant [45 CFR §400.93].

An applicant for RMA must provide proof, in the form of documentation issued by the USCIS, of having or having held one of the defined refugee statuses as defined in 45 CFR §400.43. Any national of Cuba or Haiti who has an application for asylum pending with the U.S. Department of Homeland Security (DHS) and a final non-appealable and legally enforceable Order of Removal has not been entered, is eligible for RMA for a period of no more than eight months from the date of entry [Public Law 96-422].

B. Determination of Eligibility under other programs

Effective January 1, 2014 refugees will be enrolled into the Affordable Care Act (ACA) expanded Medicaid programs. Most refugees will qualify for Medicaid under the new expanded programs. We anticipate that enrollment in RMA will be limited to individuals who lose eligibility for full family Medicaid due to earnings from employment in accordance with 45 CFR §400.104(b)Refugees applying for medical assistance must establish eligibility in the following priority [45 CFR §400.94]:

1) Medicaid full benefit programs

2) Medicaid alternative benefit programs

3) Other Medicaid options currently in place in the State of New Mexico

4) Refugee Medical Assistance

C. Eligibility for Medicaid

1) Refugees applying for Medicaid and Children's Health Insurance Program (CHIP) must meet the same eligibility criteria as any other non-refugee applicants with the exception of citizenship and enumeration.

2) If a refugee loses eligibility for Medicaid due to earnings from employment the family will be transferred to Transitional Medicaid for a period of 12 months. If a refugee is receiving Medicaid and has been residing in the U.S. fewer than 8 months becomes ineligible for Medicaid due to earnings from employment, and is not eligible for Transitional Medicaid, the refugee must be transferred to RMA for the remainder of the 8 month eligibility period without an RMA eligibility determination [45 CFR §400.104(b)].

D. Eligibility for Refugee Medical Assistance (RMA)

Eligibility for RMA is not contingent on the refugee's application for or receipt of RCA [45 CFR §400.100 (c)] and is limited to those refugees who:

1) Are ineligible for Medicaid or CHIP;

2) Are new arrivals who have resided in the U.S. less than eight (8) months;

3) Are asylees who have received their Grant of Asylum no more than eight months prior to the date of application for RMA;

4) Meet the immigration status and identification requirements establishing refugee status; and

5) Are not full time students in institutions of higher education, except where such enrollment has been approved as part of the refugee's individual employment plan or plan for a refugee unaccompanied minor.

E. Eligibility Process

The eligibility process for RMA shall follow that of Medicaid and other State operated medical assistance programs [45 CFR §400.101 and 45 CFR §400.102]. This includes the following:

1) the determination of initial eligibility;

2) the budgeting methods, including gross income, net income, and standard needs budget;

3) the treatment of income, assets, and resources, including disregards;

4) the treatment of shelter, utilities, and similar needs; and

5) the determination of benefit amounts.

F. Refugee specific eligibility criteria are:

1) HSD may not consider in-kind services and shelter provided to an applicant by a sponsor or local refugee resettlement agency in determining eligibility for and receipt of RMA.

2) HSD may not consider any cash assistance payments provided to an applicant in determining eligibility for and receipt of RMA.

3) HSD will base eligibility for RMA on the applicant's income and resources on the date of application.

4) HSD may not use income averaging prospectively over the application period in determining eligibility for RMA.

G. Compliance with 45 CFR §400.94

1) To ensure compliance with the federal regulation governing the determination of eligibility for refugees applying for medical assistance, ISD and MAD jointly issued to all ISD field offices a "General Instruction" (GI), GI07-57, that clearly defines the policies and procedures for RMA determinations. A copy of the GI is provided as Attachment 2.

2) The SRC will provide annual training on RMA eligibility to the ISD Trainers who are responsible for providing training to the Financial Assistance Analysts who determine benefit eligibility in the county offices.

3) All RMA intakes will be regularly reviewed by a supervisor at the ISD field office level and all newly approved RMA cases will be reviewed monthly by the SRC to ensure compliance with all regulations and procedures.

3. HEALTH SCREENING PROGRAM

All newly arrived refugees must be provided a health screening within the first 90 days after a refugee's initial date of entry into the United States [45 CFR §400.107(f)]. To best serve the refugee, the local resettlement agencies work with DOH to schedule the medical screening to take place within 30 days of arrival, or as soon as practicable.

HSD has arranged for all health screenings, including a mental health screening, to be conducted by DOH. The staffing and administrative costs for this utilized CMA funds and are provided through a General Services Agreement (GSA) between HSD and DOH. Medical expenses related to the health screenings are billed though to Medicaid, if the individual is Medicaid eligible, or RMA if the individual is not eligible for Medicaid and receives RMA. With the implementation of ACA expanded Medicaid programs in the state HSD projects that most medical costs related to health screenings will now be billed to Medicaid. HSD anticipates that there may still be individuals who remain Medicaid ineligible and medical costs related to health screenings for those individuals will be billed to RMA. HSD and DOH have reviewed ORR State Letter 12-09 and assure compliance with the medical screening and reimbursement framework defined therein. DOH has developed a Refugee Health Screening Protocol included in Attachment 3. Costs related to the provision of vaccinations and for testing are outlined in Attachment 4.

All refugee health screenings and associated data collection activities are conducted by a Registered Nurse (RN) employed by DOH and assigned to the Refugee Health Program in consultation with ISD.

When refugees are identified through the Health Screening process, or by virtue of an illness or condition previously identified during refugee processing, referrals for monitoring, treatment and appropriate follow-up are immediately made to local health care providers. The local resettlement agency, as part of their Reception and Placement case management responsibility, assists in ensuring that the refugee cooperates with any treatment plan developed.

Sickle Cell Anemia has emerged as a health concern for refugees resettling in New Mexico. Testing for Sickle Cell Anemia has been incorporated into the most current Refugee Health Screening Protocol. Individuals testing positive for Sickle Cell Anemia will be provided with information regarding the condition and potential risks related to high elevation as well as referrals for treatment services.

Efforts are made to complete the refugee's health screening within the first thirty days after the date of arrival. This proactive approach to health screenings is intended to:

A. Prevent and control health problems of public health significance among refugees by providing follow-up treatment and ongoing monitoring that will rapidly reduce infectiousness and transmission of any identified disease.

B. Identify refugees infected with tuberculosis (TB), Latent TB Infection (LTBI) or other infectious or communicable diseases.

C. Identify and treat illnesses or conditions that might interfere with participation in the resettlement process, including the search for employment or attendance at school.

D. Provide mental health screenings to identify symptoms indicative of social/cultural adjustment problems and provide appropriate referrals.

UNACCOMPANIED REFUGEE MINOR PROGRAM

New Mexico is not currently under contract with the ORR to resettle refugee minors through the Unaccompanied Refugee Minor Program (URMP). Should the need arise; New Mexico will implement the following protocols regarding the resettlement of unaccompanied refugee minors.

1. UNACCOMPANIED REFUGEE MINOR'S PROGRAM (REFUGEE FOSTER CARE)

A. Definition of an Unaccompanied Refugee Minor (URM)

1) A person who has not attained 18 years of age; and

2) Who has entered the United States unaccompanied by a parent, a close non-parental adult relative, or an adult with a clear and court-verified claim to custody of the minor who is willing to take care for the child; and

3) Is not destined to join a parent, close non-parental adult relative, or an adult with a clear and court-verified claim to custody of the minor who is willing to take care for the child; and

4) Has no parent in the United States.

B. Refugee Foster Care Services

HSD will establish an active ongoing foster parent program to furnish long-term foster care for refuge unaccompanied minor children. The HSD will contract with local agencies for foster care services for URMs [45 CFR §400.5(e)].

2. CONTRACTING

Under contract with HSD, an extensive program will be undertaken by the contracted agency(s) to monitor the adjustment of the minors into society. As youth become old enough and demonstrate self-reliance, they will be emancipated. They will be given educational opportunities and helped into employment, then supervised for a time in independent living before emancipation from the program.

3. ASSURANCES

HSD is committed to ensuring that children served in the URMP will receive the same services and supports as other children of the same age under the New Mexico Foster Care Program. This includes:

A. Services meeting the child welfare standards, practices, and procedures;

B. Foster care maintenance payments under Title IV-E of the Social Security Act, if the child is eligible under that program;

C. Establishment of custody and legal responsibility. The State of New Mexico requires establishment of legal custody within 10 days of the minor's arrival;

D. Recruitment, selection, and training of foster parents for their role in working with refugee children;

E. Working to encourage ethnic association, mutual support, and support of the child's ethnic identity, values, and beliefs as well as assisting in their acculturation into American and New Mexico society through English Language Training and other activities; and

F. Actively pursue family unification. However, contact with the child's parents or relatives in their native country may not be sought if such contact presents danger to relatives there.

4. MONITORING

The URMP will be monitored by HSD. Site visits will be made quarterly to conduct formal on-site reviews. The agencies will be responsible for conducting a complete annual fiscal audit. In addition, quarterly and year-end reports will be required.

5. REPORTING

The Refugee Unaccompanied Minor Placement Report (ORR-3) and the Refugee and Entrant Unaccompanied Minor Progress Report (ORR-4) will be completed by HSD and submitted to ORR. Trimester reports and monthly billings from the resettlement agency will be reviewed by the SRC for accuracy prior to authorization of contract payments.

CUBAN/HAITIAN ENTRANT PROGRAM

The State of New Mexico, HSD will apply the same standards and criteria to Cuban Haitian Entrants as are used in determining eligibility for cash, medical assistance, and social services for other eligible refugees with respect to Title V of the Refugee Education Assistance Act of 1980, [Pub. L. No. 96-422], and supporting regulations and directives of the ORR (ORR) at 45 CFR 400 and 45 CFR 401.

REFUGEE SOCIAL SERVICES

1. REFUGEE SOCIAL SERVICES PROGRAM (RSSP)

The New Mexico RSSP includes a variety of services designed to enhance employability, self-sufficiency, and self-reliance, involving public and private agencies. Within the categories of Employability Services [45 CFR §400.154] and Other Services [45 CFR §400.155] are specific programs that focus on employment, education, cultural orientation, ELT and acculturation.

A. Eligibility

The State of New Mexico will ensure that eligibility to receive social services and/or targeted assistance services are limited to the refugee population who, as provided in 45 CFR §400.150 and 45 CFR §400.152, have:

1) Provided documented proof, issued by the USCIS, of having or having held one of the refugee statuses as defined in 45 CFR §400.43. An applicant for asylum is not eligible for assistance unless otherwise provided by Federal Law [45 CFR §400.44]. Any national of Cuba or Haiti with a pending application for asylum with the DHS and has not been issued a final, non-appealable, and legally enforceable Order of Removal, is eligible for refugee social services [Public Law 96-422].

2) Resided in the United States for 60 months or less.

3) Referral, interpreter, citizenship, and naturalization services may be provided to refugees regardless of their length of residence in the United States.

B. Participation Requirements for RCA Recipients

1) A refugee receiving RCA will not be required to meet the work participation requirements of the NMW work programs [45 CFR §400.67]. However, requirements for RCA recipients, not exempted, include:

   a) Participation in employability services program provided by the resettlement agency including:

      (1) the development of an individual employability plan;

      (2) employment orientation services;

      (3) job development services;

(4) job referral services; and

(5) job placement services [45 CFR §400.154].

2) Participation in available social adjustment (acculturation) services or targeted assistance activities determined to be appropriate.

3) Participation in ELT provided as a concurrent activity to other employment activities.

C. Priorities for Provision of Service

The State of New Mexico will comply with the established priorities for services, with the highest priority from top down as listed below [45 CFR §400.147]:

1) All newly arrived refugees during their first year in the U.S. who apply for services;

2) Refugees who are receiving cash assistance;

3) Unemployed refugees who are not receiving cash assistance; and

4) Employed refugees in need of services to retain employment or to attain economic independence.

D. Access to Refugee Social Services

The State of New Mexico has contracted with local resettlement agencies to implement the RSSP. Potentially eligible refugees, asylees and Cuban/Haitian entrants will participate in the initial intake interview process with the resettlement agency. Family self-sufficiency plans and individual employability plans will be developed with refugees during an intake interview. Should services from State agencies be required to meet the specifications of the self-sufficiency or employability plans, case managers from the resettlement agency will facilitate referrals to the appropriate State agency and make copies of the plan(s) available to them at the time of the application.

2. EMPLOYABILITY SERVICES

A. Refugee Employment Program

The purpose of the refugee employment program, administered by the local resettlement agencies, is to promote economic self-sufficiency through employment within the shortest possible time after entrance for refugees, asylees and Cuban/Haitian entrants. The job developers with the resettlement agencies will develop job opportunities and refer

qualified refugees to these positions. Emphasis on job readiness and employment will continue to be the first priority. The RSSP has the following objectives:

1) To provide job development activities in order to enhance the number of employment positions available for refugees;

2) To provide job coaching services and interview refugees to determine job needs and to refer refugees to jobs; and

3) To assist refugees to gain employment and achieve economic self-sufficiency as quickly as possible after arrival.

B. Employment Assessment and Counseling

1) Following the employability intake and assessment interview, the resettlement agency's case manager will compare the client's qualifications with jobs that have been developed with local employers. If no employment possibilities are readily available, the worker will conduct a search for appropriate job openings and contact other specialists and agencies for possible employment leads.

2) Once employment has been secured, the case manager will follow-up with the refugee's employer to determine if further assistance is needed.

3) HSD staff will monitor contracted agencies to ensure the coordination of employment and acculturation services is successful and to provide technical assistance as necessary.

C. ELT

In many instances, successful integration and employability depends upon on the acquisition of language and employment skills. Refugees are encouraged to continue their ELT after employment is attained. Emphasis is placed on continued acquisition of English language skills as a means to increase employment and advancement opportunities.

The New Mexico State Adult Basic Education (ABE) system has the flexibility and resources to develop such courses throughout the State as needs arise. Monitoring and technical assistance capabilities of the New Mexico State Office of Education are valuable assets in ensuring quality educational services to the refugees. The ELT services are concurrent with employment services and are provided by the resettlement agencies.

The Educational Priorities for ELT are:

1) Survival Orientation (Health, Housing, Home Management, Employment, etc.)

Employment, cultural and community orientation concepts and understandings are vitally needed by the refugee upon his/her arrival in New Mexico. ABE proposed that these concepts and understandings should be provided to the refugees in their native tongue.

2) Survival Speaking and Listening

Standards of competency will be prescribed by the local program and monitored through periodic testing. Development of English language skills will assist in integration and employability for the refugee specifically in areas of consumer economics, health, community resources, government and law.

3) Survival Reading and Writing

Standards of competency will be prescribed by the local program and monitored through periodic testing. Additional emphasis will be directed toward language proficiency for passing the Citizenship Test that is required for Naturalization.

4) Vocational Speaking, Listening, Reading, and Writing

Standards of competency will be prescribed by the local program. Skills taught will enable the student to function effectively in society in the areas of employment. This level of English language training is employment specific and prepares the refugees to:

a) Understand basic instructions
b) Comprehend and complete job applications
c) Make interview appointments
d) Compete for promotions
e) Converse about past work experiences
f) Conduct job searches and read want ads
g) Write a resume and cover letter
h) Communicate with co-workers and supervisors
i) Handle criticism
j) Follow directions
k) Be assertive
l) Manage time and attendance
m) Learn job specific terminology

D. Case Management

Case management is conducted within the RSSP by local resettlement agencies to facilitate the refugees' utilization of appropriate programs and services that reduce barriers to early employment.

Case management begins soon after the refugee's arrival in New Mexico and focuses on:

1) Assessing refugees in regard to their need for services that can assist in overcoming barriers to early employment;

2) Developing with the refugee an individualized employment plan that includes referrals for services needed to enhance his/her employability. Such referrals may include accessing childcare services, ELT services, employment training services and skills recertification services;

3) Providing on-going case management to ensure that the refugee is accessing services and making progress through periodic contact with both the refugee and service providers; and

4) Documenting problems encountered by the refugee and revising his/her self-sufficiency and/or employability plans as appropriate.

3. OTHER SERVICES

A. Social Acculturation and Adjustment Program

The Department will work with the resettlement agencies, MAAs, local government agencies, and service providers in developing refugee social acculturation and adjustment programs.

1) Arriving refugees in New Mexico are faced with the difficult task of adjusting to American culture and a new way of life. Some of the most common issues in adjusting are: developing home management skills; a need for consumer and financial education; cultural integration; linguistic isolation; developing new skills to replace non-transferable job skills, and overcoming refugee trauma.

2) Through the utilization of various community resources, services will be offered to respond to the problem areas identified above, and, over time, these problems can be addressed and corrected. Some of these service methodologies are:

   a) Volunteerism:

(1) Assisting community volunteers to provide mentoring support in developing coping skills for successful refugee resettlement

(2) Working cooperatively with other refugee related agencies and refugee volunteers, especially in areas where there is a shortage of funded refugee services

b) Recruiting successfully resettled refugees to mentor new arrivals by sharing their experiences in developing resettlement skills

c) Training and Education:

(1) Professional training for refugees in home management skills and basic consumer and financial management skills

(2) Consumer information on comparison shopping techniques

(3) Simple, language appropriate, leaflets and fact sheets that can be utilized by refugees to recognize and negotiate their way through daily activities including encounters with stores, banks, transportation systems, etc.

B. Health-Related Services - Mental Health Program

Consistent with 45 CFR §400.155(c)(2), health-related services that help refugees understand and identify their mental health needs are made available.

Depression and other symptoms of stress are barriers to effective resettlement. Compounding the situation is the sorrow, homesickness and the insecurity of isolation from their past environments. Additionally, there are role reversals, inter-generational conflicts, and reduced social status that commonly occur within refugee families. Refugees, in general, are vulnerable and in need of ongoing services related to mental health issues.

The core objective of the Mental Health component of RSSP is the coordination of assessment and referral services for refugees with mental health needs. This component provides access and linkage to community referral networks which include, but are not limited to: local refugee resettlement agencies, social service providers, MAAs, vocational training and ELT providers, crisis intervention services, community mental health services, hospitals, emergency centers, local school districts, local health departments, and the police.

Case managers help identify potential mental health related needs. When a potential mental health issue is identified, a referral for assessment is made. The State of New

Mexico has a Refugee Mental Health Coordinator under contract. The Refugee Mental Health Coordinator provides initial assessmentsand referrals for refugees with mental health needs.

If, after the initial assessment, further referrals are needed, they are made to a network of providers experienced in working with refugees. The case manager is available throughout the assessment and referral process to assist in scheduling appointments and overcoming any barriers to service.

LANGUAGE ASSISTANCE TO PERSONS WITH LIMITED ENGLISH LANGUAGE PROFICIENCY

1. NON-DISCRIMINATION

To ensure that refugees with limited English proficiency (LEP) are not discriminated against, HSD will comply with 45 CFR §400.55 as follows:

HSD Client Forms are currently available in both English and Spanish. Additionally, the Department will conduct an annual assessment of language assistance needs by the use of a survey of its existing and potential customer base for refugee services. HSD will survey refugee resettlement agencies and service providers to gather and provide statistical information on the refugee languages within the State. This survey will include, but may not be limited to, the local refugee resettlement agency, DOH, and the Albuquerque Public School District. The survey will assist in the following:

a) Identifying the languages encountered.

b) Estimating the number of people eligible for services by each identified language group.

HSD will make available written policies for the RMA and RCA programs, including eligibility standards, duration, and amount of cash assistance payments, the requirements for participation in services, the penalties for non-cooperation, and client rights and responsibilities. For refugee language groups that constitute a small number of individuals, alternative methods, such as verbal translation as described below, will be employed to communicate HSD policies. When alternative methods are utilized, appropriate notations will be made in the case file. Further steps taken to ensure that persons with LEP are provided with non-discriminatory service include:

a) Interpreter services, provided by the resettlement agency, to assist in the initial reception and application for services. The local resettlement agencies are also contracted to provide interpreter services during the development of the refugee's employment plan.

b) Language identification cards are issued to the refugee and their family by the local resettlement agency. The ISD caseworker will identify the refugee's language needs in the case file for future reference.

c) The availability of interpretive services at all HSD office is required by HSD. A person with LEP may request to utilize his or her own interpreter. HSD implements the following procedures in that instance:

(1) If a refugee brings his/her own interpreter, the refugee shall be informed that he/she has the right to use an interpreter provided by HSD. If the refugee provides an interpreter who is not competent in the skill of interpreting, i.e. proficient in both languages and familiar with department terminology, to provide the refugee a clear and correct interpretation of verbal information and translation of the documents, HSD will provide an appropriate language interpreter.

(2) If, after being informed of the right to a HSD provided interpreter, a refugee declines such services and requests the use of a family member or friend, the refugee may use the family member or friend, if the use of such a person will not compromise eligibility or violate the refugee's confidentiality. The caseworker will document the offer of a HSD interpreter and the declination for each contact in which the use of a HSD interpreter was declined.

2. LANGUAGE ACCESS

A. All refugees are provided a written notification of their right to have all documents and notices translated orally at no cost to them.

B. Written notices are computer generated by the State's mainframe eligibility system. These notices are mailed automatically to the customer from a centralized automated mailing system. The majority of these notices deal with eligibility determination, benefit level, change in benefits, and notice of rights to appeal. Currently, all notices are printed in English with instructions written in Spanish and Vietnamese regarding how to obtain further assistance. ISD is in the process of converting all client issued notices to be issued in both English and Spanish. These notices will retain instructions written in Vietnamese regarding how to obtain further assistance.

C. For refugee language groups that constitute a small number of individuals, alternative methods, such as verbal translation as described below, will be employed to communicate HSD policies. When alternative methods are utilized, appropriate notations will be made in the case file.

D. The Department maintains a list of bilingual staff within each local ISD office that identifies the staff with second language capabilities. If bilingual staff with the

appropriate language is not available at the local ISD office, the caseworker will employ the use of The Language Line.

3. STAFF TRAINING

Training on LEP requirements is included in HSD's New Employee training program.

A. Refresher training is provided annually to all field staff.

B. Distribution of a Refugee Rights and Benefits Manual being developed by the Refugee Coordinator.

4. COMPLIANCE MONITORING

A. The Department will provide an annual monitoring of the language assistance provided to persons with LEP in accessing the refugee program and services.

B. Refugees, refugee service providers, and advocates will be surveyed to assess the language assistance provided to persons with LEP.

MISCELLANEOUS

1. SPECIAL PROGRAMS

The State of New Mexico will seek the development of refugee programs in cooperation with local resettlement agencies local government entities, refugee service providers, MAAs, and refugees to address the needs of the refugee population. The State will actively seek or assist organizations or agencies in seeking funding for these projects through refugee formula and discretionary targeted assistance grants, as well as other public and private resources.

2. VOLUNTEERS

A host of volunteers representing neighborhoods, churches, and other informal associations provide continuing service and support to refugees at the local level. Thousands of hours are given by generous volunteers in assisting refugees to attain self-sufficiency and reach self-reliance goals.

EMERGENCY OPERATIONAL PLANNING

In the event of a public health crisis, because of an outbreak of pandemic influenza, DOH will implement its Emergency Operations Plan and will notify all its partner agencies of the guidelines it has issued in conjunction with the Center for Disease Control (CDC), the World Health Organization (WHO) and other professional organizations.

Upon receipt of such alerts and/or guidelines, ISD will notify the local resettlement agencies and begin the processes described above to inform and educate the refugee community of the steps being taken to prevent, control, and treat pandemic influenza.

Contact information for the individuals responsible for implementing and monitoring the activities conducted within the refugee communities in response to pandemic influenza are:

New Mexico Human Services Department – Income Support Division

Kresta Opperman State Refugee Coordinator	kresta.opperman@state.nm.us	505-827-7213
Darlene Maestas Bureau Chief	darlene.maestas@state.nm.us	505-827-7287

New Mexico Department of Health

Eric Gregory Bureau of Health Emergency Management	eric.gregory@state.nm.us	505-476-8217
Kenny Vigil Public Information Officer	Kennyc.vigil@state.nm.us	505-827-2619
Karen Gonzales Refugee Health Coordinator	karen.gonzales@state.nm.us	505-476-3076

Catholic Charities

Beatrice Villegas Refugee Settlement & Support Director	villegasb@ccasfnm.org	505-724-4688
James Gannon Executive Director	gannonj@ccasfnm.org	505-724-4670
Lutheran Family Services		
Tarrie Burnett Sub-Office Program Director	tarrie.burnett@lfsrm.org	505-933-7015
James Horan Vice-President - Refugee & Community Services	james.horan@lfsrm.org	303-217-5182
James Barclay President & CEO	jim.barclay@lfsrm.org	303-217-5830

HEARING PROCEDURES

The following is HSD's regulations governing the fair hearing process. These regulations apply to all programs administered by HSD including RMA and RCA [§400.23 & §400.54(b) (2)]:

FAIR HEARINGS:

A. HSD has established a hearing process that provides for impartial review of HSD actions that adversely affect public assistance program applicants and recipients. For purposes of these regulations, an applicant or recipient requesting a hearing, whether as an individual or household, is referred to as a claimant.

B. For purposes of the fair hearing process, a claimant may seek the assistance of an authorized representative. For each hearing requested, a claimant shall be required to submit a "Request for Access to Case Record" (Form ISD 121), which has been signed and dated by the claimant, and authorizes the individual named on the form ISD 121 to have access to the claimant's case file for purposes of preparing for the hearing and to represent the claimant during the hearing process.

C. Hearing Rights: The right to a hearing includes the right:

(1) To be advised of the nature and availability of a hearing;

(2) To be represented by counsel or other authorized person of the claimant's choice;

(3) To receive needed help in completing procedures necessary to start the hearing process;

(4) To receive a copy of any document contained in the claimant's record in order to prepare for the hearing;

(5) To have a hearing which safeguards the claimant's opportunity to present a case;

(6) To continue to receive the current level of benefits provided the request for hearing is received by HSD in a timely manner. For the purpose of continuing benefits, "timely manner" means an oral or written request for a hearing has been received by the Department by the end of the 13th day after the date on the notice. A Claimant that elects to continue to receive the same level of benefit pending the hearing decision shall be informed that a hearing decision in favor of the Department may result in an overpayment of benefits and a requirement that the household repay the benefits.

(7) To have prompt notice and implementation of the hearing decision; and

(8) To be advised that judicial review may be invoked to the extent such review is available under state law.

D. Representation, Hearing and Appeals Costs: HSD does not provide representation or pay for any costs incurred by the claimant in program participation hearings or in judicial appeals.

E. Notice of Rights:

(1) At the time of application for assistance, an applicant shall be informed in writing of the right to request a hearing and the method by which a hearing may be requested (either orally or in writing) if the applicant disagrees with an action taken by the Department.

(2) An applicant shall be informed that the claimant's presentation may be made by the claimant, a household member or authorized representative, such as legal counsel, a relative, friend or other spokesperson.

(3) A written reminder of the right to request a hearing is provided any time a client or household expresses disagreement with an HSD adverse action.

(4) Notice of the right to a fair hearing shall be posted in each county office, and a copy shall be given upon request to any person who has requested a hearing.

(5) A claimant shall be informed that free legal assistance may be available to assist the household.

F. Special Provisions Pertaining to Mass Changes: Special provisions apply in situations involving mass changes. These provisions are contained at 8.100.180.15 NMAC and 8.139.120.10.E NMAC.

G. Continuing Benefit for NMW Cash Assistance: If a hearing request is made in a timely manner by a NMW cash assistance benefit group, the amount of cash assistance and services issued prior to the adverse action will be continued until the hearing is resolved.

H. Continuing Food Stamp Benefits: If a hearing request is made in a timely manner by a Food Stamp recipient, the amount of Food Stamp benefits issued prior to the adverse action will be continued until the hearing is resolved, provided that the household complies with re-certification provisions at 8.139.120.8 NMAC, if applicable to the household during the hearing process.

[07/01/97, 04/01/98; 8.100.970.8 NMAC - Rn 8 NMAC 3.ISD.970, 04/13/2001, A, 01/01/2003]

8.100.970.9 THE HEARING PROCESS

A. Initiation of the Hearing Process:

(1) A request for hearing can be made orally or in writing.

(2) HSD staff shall consider an oral or written expression by an applicant, recipient or authorized representative that he/she wishes to appeal a decision as a request for hearing.

(3) If a recipient or applicant makes an oral request for a hearing, the HSD staff shall complete the procedures necessary to start the hearing process.

(4) Receipt of a hearing request, either orally or in writing, shall be acknowledged in writing to the claimant by the Hearings Bureau.

B. Time Limits:

(1) An applicant or recipient has 90 days from the date of notice of action to request a hearing either orally or in writing. To be considered timely, the request must be received by the HSD Hearing Bureau or the local county office no later than the close of business on the 90th day.

(2) Hearings must be conducted and a written decision issued by the appropriate HSD Division Director or designee to the claimant within 60 days from the date that the department receives the hearing request.

C. Requesting a Hearing: An applicant for, or recipient of, assistance can request a hearing if:

(1) An application for benefits or services is denied or not processed timely;

(2) Assistance or services are reduced, terminated or suspended, or the form of

payment is changed;

(3) A good cause request for not participating in the work program or child support enforcement program is denied in whole or in part;

(4) The department refuses or fails to approve a work program participation plan developed by a participant or supportive services related to it;

(5) He or she is aggrieved by any other action affecting benefit level or participation in an assistance program administered by HSD.

(6) A hearing is provided to all applicants or recipients who timely request one in accordance with these regulations.

D. Dismissal of Hearing Request: HSD may deny or dismiss a request for a hearing when:

(1) The request is not received by the close of business on the 90th day from the date of notice of action.

(2) The request is withdrawn or canceled, in writing, by the claimant or claimant's authorized representative;

(3) The sole issue presented concerns a federal or state law requiring an adjustment of assistance for all or certain classes of clients, including but not necessarily limited to a reduction, suspension or cancellation of benefits, unless the reason for the hearing request involves alleged error in the computation of benefits;

(4) The claimant fails to appear, without good cause, at a scheduled hearing; or

(5) The same issue has already been appealed and a hearing decision made.

E. Good Cause for Failing to Appear: A request for a hearing may be considered abandoned and therefore dismissed if the claimant or the claimant's authorized representative fails to appear at the time and place of the hearing unless the claimant presents good cause. A claimant may present good cause at any time during the hearing process and until ten days after the scheduled hearing date. Good cause includes a death in the family, disabling personal illness, or other significant emergencies. At the discretion of the hearing officer, other exceptional circumstances may be considered good cause.

[07/01/97, 04/01/98; 8.100.970.9 NMAC - Rn, 8 NMAC 3.ISD.971, 04/13/2001, A, 01/01/2003]

8.100.970.10 PRE-HEARING PROCEDURE

A. Notice of Hearing: Not less than ten days before a hearing, written notice shall be given to all parties involved, of the time, date and place of the hearing. With the hearing notice, claimants are also given an explanation of the hearing process and of the procedures to be followed so that they have an understanding of what is needed to give an effective presentation of their case. The county office provides information concerning resources in the community that might provide legal representation or other help concerning the hearing. Claimants are advised that HSD does not pay for their representation or legal counsel.

B. Postponement: A claimant or a claimant's authorized representative may request and be approved for one postponement of the scheduled hearing, as long as it does not interfere with the decision time frames, except that in Food Stamp cases, the time limit for action on the decision is extended for as many days as the hearing is postponed. In financial or medical assistance cases, the hearing may be postponed, but must be re-scheduled to assure that a final decision is made no more than 45 days after the hearing was initially scheduled. Requests for

more than one postponement are considered, at the discretion of the hearing officer, on a case-by-case basis.

C. Expedited Hearing: Hearing requests from food stamp households, such as migrant farm workers, that plan to move out of the State before the hearing decision would normally be made are expedited.

D. Group Hearings: A hearing officer may respond to a series of individual requests for hearings by conducting a single group hearing. Group hearing procedures apply only to cases where individual issues of fact are not disputed and where related issues of state and/or federal law, regulation or policy are the sole issues being raised. In all group hearings, the regulations governing individual hearings are followed. Each individual claimant is permitted to present his/her own case or to be represented by his/her authorized attorney or other authorized person. If a group hearing is arranged, any individual claimant has the right to withdraw from the group hearing and request an individual hearing.

E. Agency Conference

(1) At the claimant's request, an agency conference may be scheduled before the hearing to discuss the issues involved in the hearing. The agency conference is optional and does not delay or replace the hearing process.

(2) Conference participants may include the claimant and/or claimant's authorized representative, the case worker, and either the supervisor or the county manager. The purpose of the conference is to informally review the agency action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the hearing may also be clarified or further defined. Regardless of the outcome of the agency conference, a hearing is still held, unless the claimant makes a written withdrawal of the request for the hearing.

(3) In cases where an applicant contests a denial of expedited service, the agency conference shall be scheduled within two working days of the request for a conference, unless the applicant requests that it be scheduled later.

(4) Applicants or recipients may request agency conferences in order to discuss actions which they claim have adverse effects on them or their household regardless of whether they request a hearing.

F. Summary of Evidence: A summary of evidence is a document prepared by the HSD staff which provides the background information needed for the hearing. The summary of evidence is to be prepared by the case worker, supervisor or other appropriate HSD staff, within seven days of receipt of the oral or written notice of a hearing request, and forwarded to the HSD Hearings Bureau. The summary contains at least the following information:

(1) Identifying information, including but not limited to claimant's name, social security number, address, and the type of assistance involved;

(2) Action, proposed action, or inaction being appealed (for example, rejection of application, proposed reduction in benefits, notice of overpayment, or discontinuance of benefits);

(3) The question or issue that must be decided at the hearing;

(4) Information on which the HSD action is based and the facts and findings related to the hearing issues, along with supporting documentation;

(5) All the applicable manual section(s) used; and

(6) Other facts, information, etc. which affected the decision.

G. **Availability of Information:** HSD staff shall:

(1) Provide, on request, in a timely manner and without charge, copies of the case file documents necessary for a claimant or authorized representative to decide whether to request a hearing, or to prepare for a hearing;

(2) Provide an interpreter to explain the hearing procedure and interpret at the hearing if the claimant speaks a language other than English and the project area in which claimant lives is required to provide bilingual staff or interpreters who speak the appropriate language;

(3) Allow the claimant or claimant's representative to examine the contents of the case file and all documents to be used at the hearing at a reasonable time before the date of the hearing, as well as during the hearing, except that confidential information, such as the nature and status of pending criminal prosecutions, is protected from inspection and release. Confidential information protected from release, and other documents or records which the claimant would not otherwise have an opportunity to challenge or contest, may not be introduced at the hearing or affect the hearing officer's decision; and

(4) Provide the claimant or the claimant's authorized representative a copy of the summary of evidence.

[07/01/97, 04/01/98; 8.100.970.10 NMAC - Rn, 8 NMAC 3.ISD.972, 04/13/2001]

8.100.970.11 HEARING STANDARDS

A. **Rights at Hearing:** The claimant is given an opportunity to:

(1) Examine the case file prior to, during and after the hearing in accordance with Paragraph 3 of Subsection G of 8.100.970.10 NMAC

(2) Present his/her case or have it presented by a an authorized representative; bring witnesses to present information that is relevant to the case and submit evidence to establish all pertinent facts and circumstances in the case;

(3) Advance arguments without undue interference; and

(4) Question or contradict any testimony or evidence, including an opportunity to confront and cross-examine HSD's witnesses.

B. **Hearing Officer:** Hearings are conducted by an impartial official who:

(1) Does not have any personal stake or involvement in the case;

(2) Was not directly involved in the determination or the action which is being contested; and

(3) Is/was not a supervisor of the eligibility worker who took the action.

(4) If the hearing officer had any involvement with the action in question, including giving advice or consultation on the points in issue, or is related in any relevant degree to the claimant or local office worker, he/she shall disqualify him/herself as the hearing officer for that case.

C. **Authority and Duties of the Hearing Officer:** The hearing officer shall:

(1) Explain how the hearing will be conducted to participants at the start of the hearing, before administering oaths;

(2) Administer oaths and affirmations;

(3) Make sure that all relevant issues are considered during the hearing;

(4) Request, receive and make part of the record all evidence necessary to decide the issues being raised;

(5) Regulate the content, conduct and the course of the hearing to ensure an orderly hearing. If a claimant, the claimant's authorized representative, any witness or other participant in the hearing refuses to cooperate or comply with rulings on the procedures and issues as determined at the discretion of the hearing officer, or acts in such a manner that an orderly hearing is not possible, the hearing officer may take appropriate measures to ensure that order is fully restored so that the claimant's opportunity to amply and fairly present his or her case is safeguarded, including, but not limited to excluding or otherwise limiting the presentation of irrelevant evidence, or terminating the hearing and making the recommendation based on the record that has been made up to the point in time that order was lost.

(6) Request, if appropriate, an independent medical assessment or professional evaluation from a source mutually satisfactory to the claimant and HSD; and

(7) Provide a hearing report and recommendation for review and final decision.

D. Appointment of Hearing Officer: A hearing officer is appointed by the Hearings Bureau Chief upon receipt of the request for hearing.

E. Evidence: Formal rules of evidence and civil procedure do not apply. A free, orderly exchange of information is necessary for the decision-making process. All relevant evidence is admissible, subject to the hearing officer's authority to limit repetitive or unduly cumulative evidence and conduct an orderly hearing.

(1) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not available to the claimant may not be presented to the hearing officer or used in making the hearing decision.

(2) **Administrative Notice:** The hearing officer may take administrative notice of any matter for which courts of this state may take judicial notice.

(3) **Privilege:** The rule of privilege applies to the extent that it is requested and recognized in civil actions in the District Courts of New Mexico.

(4) **Medical Issues:** In a case involving medical care or a medical condition, both parties have the right to examine any documents which may influence the decision. Any medical reports are made available to HSD and the claimant. If HSD has the reports, copies are provided to the claimant or his representative, without charge if and as requested.

(5) When the evidence presented at the hearing does not adequately address the relevant medical issues, additional medical information may be obtained at the discretion of the hearing officer. The additional medical information may include, but is not limited to, a medical evaluation or analysis obtained at HSD's expense, from a source satisfactory to the claimant.

F. Burden of Proof: HSD has the burden of proving the basis to support its proposed action by a preponderance of the evidence. The action or proposed action being appealed will be upheld if the evidence supporting the action is more convincing than the evidence offered in opposition to the action.

G. Record of the Hearing: A hearing is electronically recorded. The recording is kept on file in the Hearings Bureau for 60 days after the date of the hearing decision. In addition to the recorded proceedings, the record of the hearing includes any pleadings, documents or other exhibits admitted into the record. If a hearing decision is appealed, a written transcript of the hearing is prepared by HSD and a copy of the transcript shall be supplied to the claimant, or

his/her representative, free of charge.
[07/01/97; 8.100.970.11 NMAC - Rn, 8 NMAC 3.ISD.973, 04/13/2001]

8.100.970.12 CONDUCTING THE HEARING: A hearing is conducted in an orderly manner and in an informal atmosphere. The hearing is not open to the public. The hearing is conducted by telephone, unless the claimant makes a special request for the hearing to be held in person, justified by special circumstances as determined by the hearing officer on a case-by-case basis. The final decision as to whether the hearing shall be in person is made by the HSD Hearings Bureau Chief.

A. Opening the Hearing: The hearing is opened by the hearing officer. Before a hearing by telephone, the claimant is given a statement explaining the telephone procedures. Individuals present are asked to identify themselves for the record. The hearing officer explains his/her role in the proceedings, and that the final decision on the hearing request will be made by the appropriate HSD Division Director after review of the hearing officer's recommendation. The order of testimony is described and the oath is administered to all who testify at the hearing.

B. Order of Testimony: The order of testimony at the hearing proceeds as follows:

(1) HSD representative explains the department's action with reference to the applicable HSD regulations and presents evidence in support of the action;

(2) Claimant is given the opportunity to cross-examine the HSD representative(s);

(3) If HSD presents other witnesses, the order of examination of each witness is:

(a) Direct testimony of the witness;

(b) Cross examination by claimant or the claimant's representative;

(c) Examination or further questions by the hearing officer or, if requested, the HSD representative.

(4) Presentation of claimant's case. If claimant calls witnesses, the order of examination of each person is:

(a) Direct testimony of claimant and/or witness;

(b) Cross examination by HSD representative;

(c) Examination or further questions by the hearing officer or, if requested, by the claimant or the claimant's authorized representative.

(d) The claimant may give evidence on the points at issue without interference, may request proof or verification of evidence or statements made by others, and may present evidence in rebuttal;

(5) The hearing officer may direct further questions to the HSD representative, the claimant or any witnesses to clarify inconsistencies or obtain an adequate evidentiary record;

(6) The hearing officer may ask both parties to summarize and present closing arguments.

C. Written Closing Argument: If the claimant or HSD is represented by counsel or an authorized representative, the hearing officer may request that the closing argument be submitted in writing to the hearing officer.

D. Continuance: The hearing officer may continue the hearing upon the request of either party, or on his/her own motion, for admission of additional testimony or other evidence. The granting of a continuance is at the discretion of the hearing officer and can only be allowed when the timeliness of a decision is not jeopardized by the continuance or the parties have agreed

to an extension of the decision time frames. The reasons for the continuance shall be stated for the record. Written notice of the date, time and place of the continued hearing is sent to the parties if these are not set at the time of the continuance.

E Additional Documentary Evidence: If the hearing officer needs further documentary evidence, he/she may close the hearing but keep the record open and direct the parties to submit such evidence. Each party shall receive a copy of the documentary evidence being submitted and is allowed an opportunity to respond to the submission, in writing, within ten days of its receipt.

F. Re-opening a Hearing: The hearing officer, at his/her discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to resolution of a hearing request. The hearing can only be re-opened if the parties have agreed to an extension of the time frames. Written notice of the date, time and place of the re-opened hearing is sent to the parties, not less than ten days before the re-opened hearing.
[07/01/97, 04/01/98; 8.100.970.12 NMAC - Rn, 8 NMAC 3.ISD.974, 04/13/2001]

8.100.970.13 HEARING DECISION: The final decision concerning the hearing is made by the appropriate HSD Division Director after review of the record and the hearing officer's report and recommendation.

A. Decision Based on the Record: The hearing decision is based solely on the evidence introduced during the hearing. This includes evidence, the record of the testimony, all reports, documents, forms, etc., presented at the hearing, provided that the claimant had an opportunity to examine them as part of the hearing process.

B. Hearing Officer Recommendation: The hearing officer reviews the record of the hearing and all appropriate regulations, and evaluates the evidence submitted. The hearing officer submits the complete record of the hearing, along with his/her recommendation, in a standard format to the appropriate division director(s). The recommendation is made by the hearing officer within 15 days of the hearing.

C. Content of Recommendation: The hearing officer specifies the reasons for his/her conclusions, identifies the supporting evidence, references the relevant manual sections and regulations, and responds to the arguments of the parties in a written report and recommendation. The hearing officer recommends:

(1) In favor of the claimant when the action or proposed action at issue is not supported by a preponderance of the evidence available as a result of the hearing;

(2) In favor of HSD when the preponderance of the evidence, available as a result of the hearing, supports the conclusion that the action or proposed action at issue is in accordance with regulations, policy and law; or

(3) Any other result supported by the record

D. Review of Recommendation: The hearing file and recommendation are reviewed by the appropriate HSD Division Director(s) or his/her designee to ensure conformity with applicable federal and state law, regulations and policy.

E. Final Decision: The hearing officer's recommendation may be adopted or rejected in a final written decision by the appropriate HSD Division Director on the issues that were the subject of the hearing. The HSD Division Director, or his/her designee, specifies the reasons for the decision and identifies the evidence supporting the decision. No person who

participated in the original action under appeal may participate in arriving at a final decision.

F. Notice to Claimant: A claimant is notified in writing of the final decision and its effect on his/her benefits. If a claimant is represented by legal counsel, the legal counsel is mailed a copy of the decision. When a final decision is adverse to the claimant, the notice of the decision includes a statement hat the claimant has exhausted all administrative remedies open to him/her and is free to pursue judicial review of the claim. General information concerning the place, time and manner for requesting judicial review is provided with the statement.
[07/01/97, 04/01/98; 8.100.970.13 NMAC - Rn, 8 NMAC 3.ISD.975, 04/13/2001]

8.100.970.14 IMPLEMENTATION OF DECISION: HSD's final decision is binding on all issues that have been the subject of a hearing as to that client unless stayed by court order. The local county office is responsible for making sure that decisions are carried out. The decision is implemented within the time frames specified below.

A. Decision Favorable to HSD If assistance or benefits have been continued while the hearing decision was pending, and the decision is favorable to HSD, the case worker shall take immediate action to adjust the payment and file an overissuance/overpayment claim for the excess amounts paid while the decision was pending. A request for a hearing concerning this overissuance/overpayment claim is limited to alleged computation errors. The hearing decision serves as advance notice for the resulting benefit termination, reduction or adjustment.

B. If the hearing decision is that the household received benefits to which it was not entitled, HSD starts collection proceedings as specified in 8.102.640 NMAC and 8.139.640 NMAC.

C. Decision Favorable to Claimant

(1) Financial or Medical Assistance Programs: When a fair hearing decision is favorable to the claimant, the HSD worker authorizes corrective payment and/or retroactive medical assistance. For incorrectly denied cases, corrected benefits are issued retroactively in the following manner:

(a) To the date of adverse action or to the 30th day from the application date whichever is earlier; or

(b) To the first day of the month in which the case is actually eligible for benefits.

(c) For ongoing cases, the corrected financial or medical assistance payments are retroactive to the first day of the month in which the incorrect action became effective.

(2) Food Stamps: Decisions which result in benefit changes are reflected in the claimant's next authorized coupon allotment. The decision serves as verification for increased benefits.
[07/01/97; 8.100.970.13 NMAC - Rn, 8 NMAC 3.ISD.976, 04/13/2001]

8.100.970.14 JUDICIAL REVIEW:

A. Right of Appeal: If a final hearing decision upholds HSD's original action or proposed action, the claimant has the right to pursue judicial review of the decision and is so notified of that right in the decision.

B. Timeliness: Unless otherwise provided by law, within 30 days of the Division

Director's decision notice, a claimant may appeal the decision by filing a notice of appeal with the clerk of the Court of Appeals and sending a copy to the HSD Office of General Counsel.

C. Jurisdiction and Standard of Review

(1) The Court of Appeals' jurisdiction is defined by statute at Section 27-3-1 to 27-3-5 NMSA 1978 (Repl. Pamp. 1992). All appeals to the Court of Appeals are on the record made at the administrative hearing. The HSD Office of General Counsel files three copies of the hearing record with the clerk of the Court of Appeals and furnishes one copy to the claimant within 20 days after receipt of the notice of appeal.

(2) The Court of Appeals may set aside the HSD hearing decision if it finds the decision to be arbitrary, capricious or an abuse of discretion; not supported by substantial evidence in the record as a whole; or otherwise not in accordance with the law.

D. Benefits Pending Appeal: Upon motion of claimant, the Court of Appeals decides whether the filing of the appeal shall operate as a stay of the HSD decision. If a stay is granted, the HSD Office of General Counsel notifies the appropriate staff concerning benefit issuance.

E. Effect of Appeal: If the Court of Appeals decides in favor of the claimant, the HSD Office of General Counsel immediately notifies the county office as to the appropriate benefit issuance and adjustments, if any. If the decision is in favor of HSD, and a reduction has been pending the decision on appeal, an overpayment claim retroactive to the date the change should have been made is filed.

[07/01/97, 04/01/98; 8.100.970.14 NMAC - Rn, 8 NMAC 3.ISD.977, 04/13/2001]

History of 8.100.970: [Reserved]

History of Repealed Material: 8 NMAC 3.ISD General Provisions - Repealed, 07/01/97

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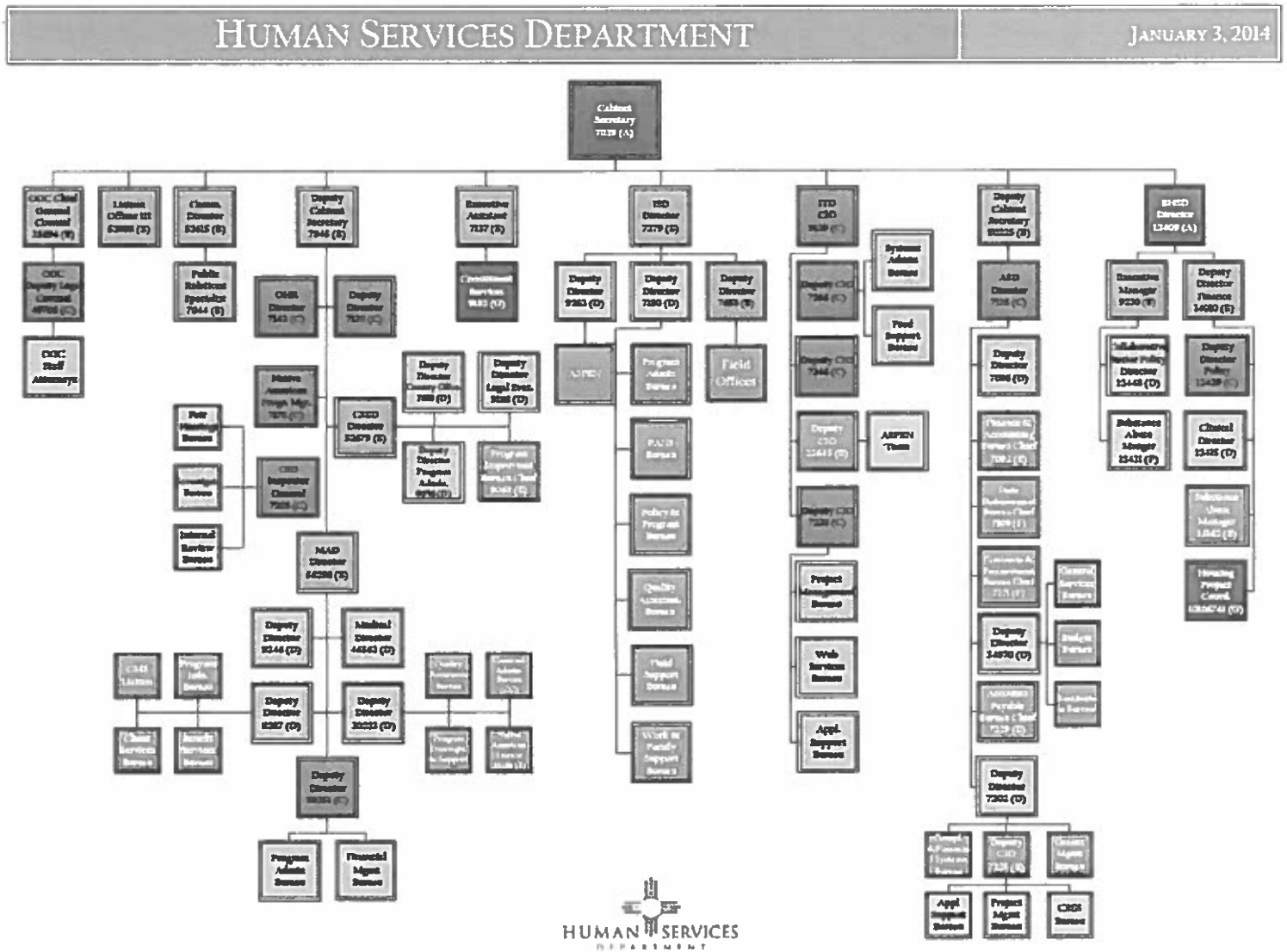
ATTACHMENT

1. HSD ORGANIZATION CHART



2. ISD-GI 07 - 57

New Mexico Human Services Department

Bill Richardson, Governor
Pamela S. Hyde, J.D., Secretary

Income Support Division
PO Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-7250; Fax: (505) 827-7203

INCOME SUPPORT DIVISION
INTERDEPARTMENTAL MEMORANDUM

ISD-GI 07- 57
DATE: September 18, 2007

TO: **ISD Staff**

FROM: **Fredrick Sandoval, Director, Income Support Division**
Carolyn Ingram, Director, Medical Assistance Division

RE: **Eligibility Determinations for Refugee Medical Assistance (Category 049)**

The U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF) Office of Refugee Resettlement (ORR) has notified us that the current procedures used for determining eligibility for Refugee Medical Assistance (RMA), Category 049, are not in compliance with 45 CFR 400.94, the regulation governing RMA eligibility determinations.

RMA (Category 49) is not funded through Medicaid. It is funded through a grant from ORR and therefore RMA should be the medical coverage of last resort. ORR regulations specify that each family member receive an individual Family Medicaid and/or State Children's Health Insurance Program (SCHIP) eligibility determination and only those individuals found ineligible may then be considered for RMA eligibility.

To insure compliance with federal regulations and NMAC 8.249.400.9 which requires that "to be eligible for refugee medical assistance, a refugee must not be eligible for Medicaid under any other category," effective immediately, all field staff must follow the following procedure when determining eligibility for RMA:

1. An applicant must present documentation issued by the U.S. Department of Homeland Security (DHS) Customs and Immigration Service (USCIS) or its predecessor agency the Immigration and Naturalization Service (INS) of one of the following immigration statuses as a condition of eligibility:

    a. Paroled as a refugee or asylee under section 212(d)5 of the Immigration and Naturalization Act (INA);

b. Admitted as a refugee under section 207 of the INA;
c. Granted asylum under section 208 of the INA;
d. Cuban and Haitian entrants in accordance with 45 CFR part 401;
e. Victims of Severe forms of Human Trafficking who present Letters of Certification from ORR;
f. Certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Act of 1988;
g. Persons admitted for permanent residence, provided the individual previously held one of the statuses identified above.

2. Each individual member of a family unit applying for medical assistance must first be assessed for eligibility for Family Medicaid (Category 72) and/or Category 32 including the State Children's Health Insurance Program (SCHIP) before eligibility for RMA is determined.

3. If there is no Family Medicaid eligibility but a child is eligible for Category 32, this case must be registered and approved for Category 32 along with a Category 049 for the adult household members. Remember that a child enrolled in Category 32 must be a nonmember of Category 049 cases.

4. Those found ineligible for Medicaid or Category 32 including SCHIP must then be assessed for RMA eligibility utilizing the current procedures.

5. Case files for all RMA applicants must contain documentation that the assessment for Medicaid and Category 32 including SCHIP eligibility was completed as part of the initial intake.

6. Remember to open a Medicaid Category 28 when a Medicaid Category 72 case is closed due to income.

If there are questions regarding the Refugee Medical Assistance Program contact Norman Levine (norman.levine@state.nm.us), or by phone at (505) 827-1343.

Access • Quality • Accountability

New Mexico Department of Health

Public Health Division

Refugee Health Protocol and Standing Orders for Public Health Division Nurses

December 2013

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INTRODUCTION:
There are over 43 million refugees and internally displaced people around the world. Each year, the President submits the Proposed Refugee Admissions Report to Congress, in compliance with Sections 207(d)(1) and (e) of the Immigration and Nationality Act (INA). Populations are categorized into three main priority groups: Priority 1: individual cases; Priority 2: key designated groups: and Priority 3: family reunification for designated nationalities. The Health and Human Services Office of Refugee Resettlement (ORR) provides fiscal support to state and local governments and volunteer refugee resettlement agencies (VOLAGs) to promote self-sufficiency among refugees through access to mainstream services such as housing, healthcare, and social services during the initial eight months of arrival into the United States (U.S.).

Refugees enter the U.S. at Centers for Disease Control and Prevention (CDC) ports of entry around the country. Relocation to Albuquerque, or elsewhere, occurs with the assistance of designated VOLAGs such as Catholic Charities and Lutheran Family Services in NM. Most refugees receive their health screening at the Southeast Heights Public Health Office (SEH PHO) in Albuquerque, which is located in the Public Health Metro Region. Refugees may choose to resettle in other areas of NM. In this case, the local public health office would be responsible for the screening. The Refugee Health Program (RHP), the refugee health nurse at the SEH PHO, and the Refugee Health Mental Health Coordinator (RHMHC) should be contacted for consultation.

The Refugee Health Program works collaboratively with the NM Human Services Department, volunteer resettlement agencies, and Public Health Offices to ensure that newly–arrived refugees have access domestic medical screening, comprehensive mental health services, culturally and linguistically appropriate language interpretation, translation of relevant written materials, and transportation to and from health/mental health screening. The health screening should take place within the first 30 days after arrival to New Mexico.

Definitions
There are several types of immigrant classification that are eligible for refugee health screening. These include:

1. Refugee: A person granted refugee status while residing abroad because he/she was unable to return to his/her native land because of past persecution or a well-founded fear of persecution based on race, religion, nationality, political opinion or membership in a particular social group. Each year, the President, in consultation with Congress, determines the number of refugees who may be admitted to the U.S. from overseas. The State Department, in cooperation with VOLAGs, facilitates the legal entry of these refugees to the U.S. after they have been granted refugee status by the Department of Homeland Security.
2. Asylee: An individual who, while physically present in the U.S., has been granted asylum by an United States Citizenship and Immigration Service (USCIS) asylum officer or an immigration judge, as a result of a fear of returning to his/her native

land because of past persecution or a well-founded fear of persecution based on race, religion, nationality, political opinion or membership in a particular social group. U.S. policy, in accordance with relevant international law, recognizes that persons fleeing persecution must often rely on irregular means of escape and may lack proper documents for arrival in a country of asylum. Like refugees admitted from overseas, persons granted asylum must meet the U.S. refugee definition, based on persecution. Persons granted asylum, known as "asylees", are eligible for permanent residence and eventual citizenship.

3. Cuban/Haitian Entrant: Any individual from Cuba or Haiti granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established, or any Cuban National who enters the U.S. at any location other than Miami, FL and placed by Immigration and Customs Enforcement (ICE) into Section 240 proceedings.
4. Iraqi or Afghan Special Immigrant (S.I.V.): An Iraqi or Afghan translator or other employee of the U.S. military or government agency who is admitted to the U.S. for Lawful Permanent Residence as a result of a threat to their well being if they remain in their homeland. These Special Immigrants are eligible for the Refugee Resettlement Program as a result of an Act of Congress. This population arrives without any copies of the overseas medical exam. They are issued a green card before arrival to the United States.
5. Amerasian: An alien born in Vietnam between January 1, 1962 and January 1, 1976, who was fathered by a U.S. citizen and admitted under special provisions of U.S. law (Section 584 of Public Law 100-102 as amended by Public Law 100-461). Spouses, children, and parent or guardian may accompany the entering alien.
6. Child or Adult Victim of Severe Forms of Human Trafficking: A person over the age of 18 who has been certified as a victim of severe forms of human trafficking as defined in the *Trafficking* of *Victims Protection Act* of *2000*, such as:
    a. Sex trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act, in which a commercial sex act is induced by force, fraud, or coercion or in which the person forced to perform such an act is under the age of 18 years; or
    b. Labor trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery.
7. Conditional Entrant: A refugee-like person who obtained such status on the basis of the immigration laws that existed prior to the Refugee Act of 1980.

Other relevant definitions include:

1. Refugee Services: Services to resettled refugees, asylees, Cuban/Haitian Entrants, etc., are designed to help them adjust to their new homeland and achieve self-sufficiency, and are funded primarily by the ORR within the Department of Health and Human Services. The refugee admissions and resettlement program is a longstanding public-private partnership, with

government funding augmented by the private resources of both faith-based and non-sectarian agencies. Up to eight months of federally funded Refugee Cash and Medical Assistance is made available through the Income Support Division, NM Human Services Department, to non-economically self-sufficient refugees, asylees and Cuban/Haitian Entrants who are not otherwise eligible for Social Security Insurance (SSI), Temporary Assistance for Needy Families (TANF) and/or Medicaid.

2. Lawful Permanent Resident (immigrant "green card" holder): An individual admitted to the U.S. for permanent residence with the ability to apply for citizenship after five years of residence in the U.S., including all the refugee and refugee-like classifications listed above, and family reunification immigrants. Only the refugee classifications may receive a refugee health screening.
3. Non-immigrant Visa Holder (tourists, students, temporary workers, etc.): An individual admitted to the U.S. on a temporary basis that may or may not have permission to work, and cannot overstay the time frame for which their visa was approved or apply for citizenship. Under certain circumstances they may apply to change status to Lawful Permanent Resident. Non-immigrants may not receive a refugee screening.

OBJECTIVE

The purpose of the domestic refugee health screening is to ensure that refugees receive treatment and care for conditions of public health significance and mental health conditions, and that such conditions do not prevent successful resettlement in the U.S.

SERVICE POPULATION

The Refugee Health Program provides integrated health/mental health screening for refugees, asylees, Cuban/Haitian Entrants, Amerasians, and victims of extreme forms of human trafficking. RHP *does not* provide refugee screening or related services for other types of immigrants or non-immigrants.

POLICY

All immigrants, including refugees are required to have a medical examination before leaving the country they resided in prior to arrival to the U.S. Some asylees and Cuban/Haitian Entrants may not have received an overseas medical exam because asylum was granted after the person was already in the U.S. Contact the Refugee Health Program Manager if the client lacks documentation of an overseas medical examination. The pre-departure medical examination procedure consists of a physical examination, an evaluation for tuberculosis and blood test for syphilis for persons 18 years or older. Applicants under the age of 18 years can be tested if there is reason to suspect any of these diseases. The vaccination requirements include vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

1. Class A conditions: Any untreated communicable disease of public health significance is a Class A condition. Potential immigrants found to have Class A conditions are not admissible to the U.S. until treated and documentation proving

treatment is approved by immigration officials. Examples of Class A conditions are: active, infectious tuberculosis; Hansen's disease; yellow fever; and current physical or mental disorder with associated harmful behavior.

2. Class B conditions: Examples of Class B conditions include active, non-infectious tuberculosis (TB), latent TB infection, and current evidence of a physical or mental disorder but no history of associated harmful behavior. A follow-up medical examination should be done within 30 days after arrival to the U.S., but is not required by law. Persons with a Class B condition may be from any of the immigrant categories mentioned above, and are not specific to refugees.

METHODOLOGY

Screenings and assessments outlined in this protocol will be performed by the public health nurse unless otherwise stated. Refugees aged birth through 14 years should be referred to a Program approved laboratory for age-appropriate testing services. The refugee health nurse will ensure that all laboratory results associated with the domestic health screening are scanned into the client's BEHR record. Copies of all laboratory results and cover sheet detailing enclosed laboratory results and special findings will be provided to the primary care provider. Clients who obtain testing services at a Program approved laboratory should present current Medicaid information in order to bill Medicaid directly. Services provided as part of the refugee health screen are listed in the NMDOH Refugee Health Domestic Screening Guidelines **(See Appendix A: NMDOH Refugee Health Domestic Screening Guidelines)**.

Reporting of Abnormal and Normal Laboratory Results

- Abnormal lab results are determined by the criteria established by the performing laboratory.
- Results reported in the laboratory's 'abnormal' range must be reported and tasked to the Regional Health Officer for review and signature
- All normal lab results will be reviewed and signed by the local nurse manager.
- Provide copies of all normal and abnormal laboratory results to the Primary Care Physician (PCP).

SECTION 1 STANDING ORDER FOR HEPATITIS SCREENING

Description of Condition

Viral hepatitis is an infection of the liver that is caused when the virus enters the blood stream of a susceptible person. Hepatitis A (HAV) is most commonly transmitted through consumption of food or water that has been contaminated with infected fecal matter. Hepatitis A infection is common in developing countries where sanitation disposal and drinking water supplies are not properly separated. Hepatitis B (HBV) is transmitted through contact with infected blood or sexual fluids. HBV can also be

transmitted from mother to child during birth. Refugees originating from highly endemic areas such as Asia, Central and Eastern Europe, and Sub-Saharan Africa are at increased risk for chronic HBV infection. Hepatitis C (HCV) is most commonly transmitted through contact with contaminated blood. Risk factors for HBV and HCV include blood transfusions, unsanitary cutting and piercing practices, injection drug use, and sharing of crack or meth pipes or intranasal inhalant equipment. HCV is not commonly transmitted through sexual activity.

Clinical Assessment

- Refugees ≥ 15 years of age
  - Test for hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (Anti-HBs), hepatitis B core antibody, total (Anti-HBc), and hepatitis B core IgM antibody (Anti-HBc IgM)
  - Test for HCV antibodies if client has a history of injection drug use, sharing glass pipes for smoking crack or meth, sharing of intranasal inhalant equipment, or blood transfusions
- Refugees ≥ 18 months and < 15 years of age
  - Refer for hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (Anti-HBs), hepatitis B core antibody, total (Anti-HBc), and hepatitis B core IgM antibody (Anti-HBc IgM) tests
  - Refer for HCV antibody test if client has risk factors (e.g., hepatitis C positive mother; history of blood transfusions; body art or surgical procedures obtained in unsterile conditions).

Normal and Abnormal Findings

See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.

Follow-up and Evaluation for Treatment and Care

- If hepatitis serology is positive, follow-up according to NMDOH Hepatitis Protocol regarding testing of household and sexual contacts, and immunization of susceptible children and adults who are susceptible (**See *Appendix B: NMDOH Recommended Adult Testing and Immunization by Risk Groups***).
- Follow-up of women of childbearing age who are hepatitis B surface antigen positive is of highest priority to prevent perinatal transmission of the infection (See Perinatal hepatitis B protocol which can be found in the clinical protocols section of the PHD intranet). Notify the Regional Health Officer and regional Hepatitis Nurse if you identify a pregnant woman who is HBV surface antigen positive.
- Provide client-centered education regarding disease process, prevention of transmission and re-infection, available harm reduction resources, importance of liver wellness, and referrals to specialty care for chronic disease management and/or treatment.
- Public health does not routinely provide hepatitis A screening

SECTION 2 STANDING ORDERS FOR HIV SCREENING

Description of Condition

The HIV/AIDS pandemic remains one of the most serious global health challenges today. The World Health Organization (WHO) estimates that at the end of 2011, 34 million people were living with HIV and 1.7 million people died of AIDS-related illnesses worldwide. While HIV/AIDS affects individuals throughout the world, certain regions, such as sub-Saharan Africa, have disproportionally high prevalence rates. In addition, HIV/AIDS disproportionately affects certain vulnerable population groups, such as young adults, women, and children. Although the link between HIV and migration is complex and nonlinear, multiple factors heighten the HIV risk for refugees such as, economic distress, conflict, social abuse and violence, oppression, discrimination, exploitation, gender bias, and sociopolitical marginalization. Domestic HIV screening is critical because prior to resettlement, refugees may have traveled to or lived in countries with high HIV prevalence rates, been victims of physical and sexual violence, unsterile medical procedures, or engaged in injection drug use.

Beginning January 4, 2010, refugees are no longer tested for HIV infection prior to arrival in the U.S. Domestic HIV screening should be performed routinely on all new arrivals, as opt-out testing (unless the individual objects to testing, it will be done automatically). Many refugees come from regions where the HIV epidemic is firmly established with primarily heterosexual transmission and the typical North American risk factors do not apply.

Clinical Assessment

All refugees, regardless of reported risk factor, should be tested for HIV on an "opt out" basis. Refer to the NMDOH Standard Operating Procedures for instructions on how to collect specimen and submit to laboratory;

- Person ≥ 15 years: utilize oral HIV-1 Orasure testing technology
- Persons birth through 14 years of age should be referred for an age-appropriate HIV test
- Repeat screening 3-6 months following resettlement is recommended for refugees with a recent exposure or increased risk for disease acquisition to identify individuals who may be in the "window period" when they arrive in the U.S. This includes persons who engaged in unprotected sexual intercourse or injection drug use 90 days prior to the initial HIV test which was conducted as part of the Domestic Health Screen. Subsequent testing should be done in accordance with CDC guidelines;
- Specific testing for HIV-2 should be conducted for refugees who screen positive for HIV and are native to or have transited through an endemic country;

Normal and Abnormal Findings
See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.

Follow-up and Evaluation for Treatment and Care

- Counseling, testing, and referrals services should be provided to persons identified as HIV positive in accordance with the NMDOH Protocol for HIV Linkage-to-Care(http://intranet/PHD/documents/linkage-to-careprotocol2011.pdf).
- The Regional Health Officer and regional Infectious Disease Nurse Supervisor (IDNS) should be notified of a positive HIV report to ensure that the client is linked to appropriate follow-up treatment and care services.
- In conjunction with the IDNS, provide client-centered education regarding disease process, prevention of disease transmission, and available harm reduction resources and case management/ treatment services.

SECTION 3 STANDING ORDERS FOR IMMUNIZATION ASSESSMENT

Description of Condition
Refugees, unlike most immigrant populations, are not required to have any vaccinations prior to arrival in the United States. Since developing countries or refugee settings have limited or no access to vaccine, most refugees, including adults, will not have had completed Advisory Committee on Immunization Practices (ACIP) recommended vaccinations when they arrive in the U.S.

Beginning in December 2012, the Division of Global Migration and Quarantine (DGMQ) of the Centers of Disease Control and Prevention (CDC), the Bureau of Population, Refugees and Migration (PRM) of the U.S. Department of State, and the International Organization of Migration (IOM) initiated a pilot vaccination program for approved refugee applicants in the U.S. Refugee Admissions Program (USRAP). The goal of the pilot project is to provide cost-effective public health interventions, improve refugee health, and limit the number of vaccinations refugees require after their arrival in the U.S. Refugees departing from Ethiopia, Kenya, Malaysia, Nepal and Thailand will receive vaccine doses at the time of initial migration health assessment, followed by doses 2 and 3 as appropriate. IOM will review vaccination records and determine whether they meet set standards. Unless medically contraindicated, refugees departing from Ethiopia, Kenya, Malaysia, Nepal, and Thailand will receive the following immunizations prior to arriving in the U.S.:

- Diphtheria, tetanus, and pertussis (DTP)
- Hepatitis B
- Haemophilus influenza type B (Hib)
- Measles, mumps and rubella (MMR)
- Oral polio virus (OPV)

- Pneumococcal conjugate 13 (PCV-13
- Pentavalent (DTP, hepatitis B, Hib)
- Tetanus, diphtheria (Td)

Vaccinations will be documented on the refugee's Vaccination Documentation Worksheet (DS-3025) as well as in the Electronic Disease Notification (EDN) System. Contact the Refugee Health Program Manager if documentation of vaccinations listed above is incomplete for refugees originating from countries that are participating in the pilot study.

Note: All live-virus vaccines will be administered in advance of departure so that refugees, if eligible, can receive live-virus vaccine and tuberculosis testing immediately after arrival in the U.S.

Clinical Assessment

All children aged birth through 18 years are eligible for immunization using NMDOH PHD Vaccine for Children (VFC) Program funded vaccine. Adult refugees should be immunized using the adult vaccine purchased through the RHP. Adults may not be vaccinated using the VFC procured vaccine. The following services should be provided as part of the domestic health exam:

- Determine the age of each refugee and review the person's medical history and records;
- Determine vaccine needs of the person according to ACIP Recommendations and current NMDOH PHD Immunization Protocol (http://intranet/PHD/documents/IZ_2013Protocol_Final.docx) and assess for medical contraindications;
- Varicella vaccine should be administered to all adults who cannot provide a reliable history of clinical chickenpox, positive serological test for immunity (not offered through PHD), or who cannot provide documentation of having received two doses of Varicella vaccine at least 28 days apart. In case of doubt, vaccine should be provided.

Follow-up and Evaluation for Treatment and Care

- Provide clients with a copy of the antigen appropriate Vaccine Information Statement (VIS) written in their primary language
- Document all historical and current vaccination data in NMSIIS and provide the refugee a copy of their immunization record. The immunization card may be kept in the zipper pocket of the Cultural Orientation binder for future reference.

SECTION 4 STANDING ORDERS FOR INTESTINAL PARASITE TREATMENT

Description of Condition
Presumptive treatment for parasitic infections are administered to most U.S.-bound refugees departing from Ethiopia, Kenya, Tanzania, Rwanda, South Africa, Uganda, Malaysia, Nepal, Thailand, Iraq, and Jordan. Persons who complete the recommended treatment regimen do not require further treatment or evaluation unless they present with clinical symptoms of infection.

Clinical Assessment

- Assess all newly-arrived refugees for completion of overseas presumptive treatment for intestinal parasites and provide presumptive treatment for soil-transmitted helminths as indicated below (**See *Appendix D: Treatment Schedules for Presumptive Parasitic Infections in U.S.-Bound Refugees, Administered by IOM – May 2013, Intestinal Parasite Guidelines for Domestic Medical Examination of Newly Arrived Refugees***).
- Persons ≥ 2 years who did not receive pre-departure presumptive treatment, did not complete the recommended treatment regimen, or who are not listed in the Treatment Schedule for Presumptive Parasitic Infections for U.S.-Bound Refugees, administered by IOM – May 2013 should be evaluated for contraindications and receive 400mg of albendozole, orally in a single dose.
- Refugees aged 12 months through 23 months, who did not complete recommended treatment regimens should be evaluated for contraindications and receive 200 mg of albendazole, orally in a single dose
- Documentation of pre-departure presumptive treatment for intestinal parasites can be found in the refugee's IOM bag. If documentation is not included in the IOM bag, contact the Refugee Health Program for Manager and request a search of the EDN System.

The following criteria should be used to assess completion of overseas presumptive treatment:

- **No presumptive treatment:** Refugees in this category did not receive presumptive treatment for parasites prior to departure for the U.S. This group includes persons from populations not included in the table of presumptive treatment programs and those excluded due to contraindications to presumptive treatment with albendazole, praziquantel, and ivermectin (**See *Appendix D: Treatment Schedules for Presumptive Parasitic Infections in U.S.-Bound Refugees, Administered by IOM – May 2013, Intestinal Parasite Guidelines for Domestic Medical Examination of Newly Arrived Refugees***).
  - Albendazole contraindications
    - Children < 1 year of age, women in the first trimester of pregnancy, refugees with known neurocysticercosis, evidence of cysticercosis (e.g. subcutaneous nodules), or with a history of unexplained seizures
  - Praziquantel contraindications;

        - Children < 4 years of age or measuring < 94 cm, refugees with known neurocysticercosis, evidence of cysticercosis (e.g. subcutaneous nodules), or with a history of unexplained seizures
    - Ivermectin contraindications:
        - Children < 15 kg or measuring < 90 cm, pregnant women in any trimester or breastfeeding women within the first week after birth
    - Refugee is departing from or has lived in a *Loa loa* endemic area (Angola, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Nigeria, and Sudan).

- **Incomplete presumptive treatment:** Refugees in this category did not receive all of the recommended overseas presumptive treatment for parasites prior to departure.
    - Most refugee populations receive a single dose of albendazole and it is reasonable to assume they have received albendazole if they are from populations included in the presumptive treatment programs and do not have contraindications to albendazole.
    - Most refugees from sub-Saharan Africa receive predeparture praziquantel treatment for schistosomiasis if they are from populations included in the presumptive treatment programs and do not have a contraindication to praziquantel.

Follow-up and Evaluation for Treatment and Care

- Common symptoms of parasitic intestinal infections include nausea, diarrhea, abdominal pain, and cramps. Refugees who present with these symptoms should be referred immediately to primary care for further evaluation and treatment. Some parasitic infections such as schistosomiasis, may present with cough (not improving, TB screen is negative) or central nervous system symptoms in addition to gastrointestinal complaints.
- Discuss with PHD Regional Health Officer or Infectious Disease Bureau physician and Primary Care Physician (PCP) if you suspect active infection.
- Refugees who did not complete presumptive treatment for strongyloidiasis or schistosomiasis should be referred to a primary care physician for follow-up and treatment.
- Provide education the importance of proper hand washing techniques to prevent the spread of infection.

SECTION 5 STANDING ORDERS FOR LEAD SCREENING

Description of Condition

During 2009 and 2010, New Mexico conducted a pilot lead screening program to determine whether lead screening should be permanently incorporated into the refugee screening. The program has decided to continue lead screening in light of current

national recommendations in which high lead levels have been identified in certain refugee populations.

Clinical Assessment

- Each child from 6 months to 16 years of age should be screened at the time of arrival to assess lead burden due to their situation in their country of prior residence.
- Persons aged 15-16 years should receive a blood lead test as part of the domestic health screen. Lead testing kits are provided by Medtox, 1-877-725-7241; include Medicaid information on requisition to ensure that Medicaid is billed directly
- Persons aged 6 months through 14 years should be referred to a Program approved laboratory for testing.

Normal and Abnormal Findings

See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.

Follow-up and Evaluation for Treatment and Care

If possible, conduct a second screening six months after the first screening for all children under 6 years old. Make the appointment during the initial screening, and provide the client with a reminder card with the second appointment date and time.

SECTION 6 STANDING ORDERS FOR MALARIA SCREENING

Description of Condition

Malaria is a serious and sometimes fatal disease caused when a susceptible human is inoculated by an Anopheles mosquito that is infected by *Plasmodium* species. The parasite replicates in the liver and blood cells.

Beginning in late 2007, refugees from sub-Saharan Africa who are relocating to the United States receive presumptive treatment of asymptomatic *P. falciparum* prior to departing from their home country. Refugees who have received pre-departure treatment with a recommended antimalarial drug or drug combination (Atovaquone-proguanil, trade name Malarone, or artemether-lumefantrine, trade names Coartem, Riamet) do not need further evaluation or treatment for malaria unless they have clinical symptoms.

Clinical Assessment

Refugees from highly endemic areas such as sub-Saharan Africa or Southeast Asia who have not received pre-departure therapy or who do not have documentation of pre-departure therapy should receive a Malaria parasite blood smear as part of their routine

domestic health screen. Children birth through 14 years of age should be referred to a Program approved laboratory for Malaria testing.

Note: All Malaria tests processed through the Public Health Office must have the collection date and time clearly written on the label. The laboratory must receive the specimen within **48 hours** from time of collection or it will be rejected.

Normal and Abnormal Findings
See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.

Follow-up and Evaluation for Treatment and Care

- A positive smear should also identify the species of malaria infecting the patient. Falciparum malaria should be treated with atovaqone-proguanil or artemether-lumefantrine (alternatives can be discussed on a case by case basis). If identified, non-falciparum malaria may include infection with *P. ovale* and *P. vivax* that have dormant phases that require treatment with a 14-day course of primaquine as well for eradication. Contact the Regional Health Officer or PHD Infectious Disease physicians to discuss appropriate treatment and dosing instructions.
- Previous malaria history (especially within the last 1-2 years) should be noted in the medical record.
- New arrivals should be counseled to seek medical care if signs/symptoms develop suggestive of recurrence. These symptoms include fever, anemia, splenomegaly, chills, headache, backache, and malaise. If these symptoms are present during initial screening, discuss with Regional Health Officer or Infectious Disease Bureau physician.

SECTION 7 STANDING ORDERS FOR MENTAL HEALTH SERVICES

Description of Condition
Many refugees, if not most, will have experienced some sort of violence, atrocity or human rights abuse. Due to issues of language, culture, and the nature of traumatic experience, many of these issues can go undetected as refugees try to assimilate into a new country and culture. Such dynamics increase the likelihood of ongoing vulnerability and marginalization within refugee populations. These issues also require that treatment or service provision be tailored to the population.

The Refugee Health Program has developed a comprehensive refugee mental health component to identify and treat mental health issues that could interfere with successful resettlement in NM. The Refugee Mental Health Coordinator (RMHC) will perform the following tasks:

- Serve as the main contact for all mental health related issues regarding newly-arrived refugees

- Serve as the clearinghouse for all mental health referrals for newly-arrived refugees
- Oversee mental health services of all newly-arrived refugees
- Provide initial mental health screening to all newly-arrived refugees, as part of the health screen
- Provide comprehensive mental health assessments to eligible refugees
- Facilitate referrals for mental health follow-up and treatment services
- Provide follow-up services, as needed, to refugees who are assessed
- Provide mental health training to private and public providers to build capacity of refugee mental health provider referral network
- Provide mental health awareness and decompression sessions for refugees as part of regularly scheduled cultural orientation classes
- Provide mental health trainings to public and private healthcare providers and community-based organizations serving refugees
- Build and maintain a network of refugee mental health providers

Process for referring refugees for mental health services
Mental health services will be provided to eligible refugees according to the following procedure:

- All newly-arrived refugees will receive an initial mental health screening as part of the domestic health screening. The screening may be conducted by the refugee health nurse and should assess any changes in appetite, sleeping patterns, nightmares, pain and energy level. The RMHC should be notified of any changes or concerns reported by the client.
- A secondary mental health screening, utilizing the RHS-15 screening tool, will be administered by the RMHC on the second visit during the domestic health screening follow-up appointment
- The RMHC should be notified of any refugee experiencing the symptoms noted above, or who scores positive on the RHS-15, or who is referred based on signs of stress and trauma. The RMHC will conduct more comprehensive assessments utilizing a narrative approach and age-appropriate diagnostic tools. Referrals for assessment may be made by the refugee health nurse, VOLAG staff or volunteer, a member of the provider network, other agency, or by request of the client or client's family
- RMHC will provide referrals for follow-up and treatment services based on the results of the mental health assessment, clinical assessment of the individual needs of the client, and available resources.
- Most refugees will be screened at the Southeast Heights Health Office. Contact the Refugee Health Program Manager or RMHC for consultation if a refugee presents at a different health office.

SECTION 8 STANDING ORDERS FOR NUTRITIONAL ASSESSMENT

Description of Condition
Studies have documented under nutrition and poor growth among refugee children arriving in the United States. Similarly, issues have been noted among refugee children who are overweight upon arrival to the US or become overweight after having lived here for a short period of time. A nutritional assessment should be conducted to identify any related health issues. The following should be done in order to assess the nutritional status of newly-arrived refugees:

Clinical Assessment
- Calculate body mass index (BMI)
- Refer children birth through 14 years of age for Complete Blood Count (CBC) with differential and Comprehensive Metabolic Profile (CMP)
- Assess immediate needs for food

Normal and Abnormal Findings
See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.

Follow-up and Evaluation for Treatment and Care
- Refer to PCP if iron deficient or for further assessment
- If applicable, provide client with information regarding nutritional support services, such as WIC.

SECTION 9 STANDING ORDERS FOR PREGNANCY SCREENING

Description of Condition
Knowledge of pregnancy status is critical to assess administration of medication for the treatment for intestinal parasites and malaria. Treatment for these conditions is contraindicated for pregnant women. Special precautions should be taken with women who are diagnosed with hepatitis, HIV, and STIs to prevent transmission of the infection to the baby.

Clinical Assessment
Women and girls of child-bearing age should receive pregnancy test using opt-out approach

Normal and Abnormal Findings
See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.

Follow-up and Evaluation for Treatment and Care

- If history or symptoms warrant, perform a pregnancy test. (See NMDOH PHD Family Planning protocol which can be found in the clinical protocols section of the PHD Intranet on how to be reasonably sure someone is not pregnant.)
- Regional Health Officer and/ or PHD Infectious Disease Physician should be notified of pregnancy status when abnormal lab results are reported.
- Provide pregnant women with educational material regarding the importance and availability of prophylactic treatment of infectious disease and prenatal care.

SECTION 10 STANDING ORDERS FOR SCREENING OF SEXUALLY TRANSMITTED INFECTIONS

Description of Condition

The prevalence of Sexually Transmitted Infections (STIs) in refugee populations is not well characterized and likely varies among populations. Because certain refugee groups are at potentially high risk for STIs, it is important to screen in order to minimize or prevent acute and chronic sequlae, as well as prevent transmission to others. Many times refugees are the victims of sexual violence and are not forthcoming about reporting this risk.

Clinical Assessment

- All refugees ≥ 15 years of age regardless of reported risk factors or overseas medical history:
  - Test for syphilis infection
  - Test for Chlamydia and Gonorrhea (CT/GC) infections
- Refugees birth through 14 years of age
  - Refer for syphilis test if person is sexually active or report risk factors such as a family member with positive syphilis diagnosis or history of sexual abuse
  - Refer for Chlamydia and Gonorrhea (CT/GC) test if sexually active or report a history of sexual abuse

Normal and Abnormal Findings

See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.

Follow-up and Evaluation for Treatment and Care

- Follow the NMDOH STD and HIV Protocols to determine appropriate treatment and follow-up of contacts of persons with a positive STI screen (http://intranet/PHD/documents/STDPROTOCOL_August2012_FINAL.doc).
- Provide client-centered education regarding disease process, prevention of transmission and possible re-infection, available harm reduction and family planning services

SECTION 11 STANDING ORDERS FOR SICKLE CELL SCREENING

Description of Condition
Sickle Cell Disease (SCD) is a group of inherited red blood cell disorders. It is caused when a child receives two sickle cell genes, one from each parent. Healthy red blood cells are round, and they move through small blood vessels to carry oxygen to all parts of the body. In someone who has SCD, the red blood cells are crescent-shaped and become hard and sticky. Sickle cells tend to block the flow of blood in the blood vessels of limbs and organs.

Symptoms of SCD are generally detectable after the child is 5 months of age. Prior to that age fetal hemoglobin protects the red blood cells from sickling. Symptoms may include the following:

- Anemia – chronic shortage of red blood cells. Iron supplements will not help with type of anemia and could harm person with SCD.
- Episodes of pain – Pain develops as sickle-cell shaped red blood cells block blood flow through blood vessels in the chest, abdomen, and joints. Pain intensity and duration may vary.
- Hand-foot Syndrome – hands and feet swell because the sickle-shaped cells block blood flow from these extremities
- Frequent Infections – sickle cells can damage the spleen rendering a person less able to fight infection
- Delayed Growth – shortage of health red blood cells can slow growth in infants and children, and delay puberty in teenagers

Clinical Assessment
Refugee Health Program provides a Sickle Cell Index, which is a blood test to screen for sickle cell disease/trait to all newly-arrived refugees from sub-Saharan Africa who are ≥ 15 years of age. Persons aged birth to 14 years of age should be referred to a Program approved laboratory for Sickle Cell testing. Knowledge of this genetic disorder may help prevent decompensation due to the altitude of much of the state of New Mexico.

Normal and Abnormal Findings

- See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results.
- Notify the Refugee Health Program Manager and VOLAG case manager of a positive result in order properly track and better assist the client in finding adequate support for the condition.

Follow-up and Evaluation for Treatment and Care
Any person with a positive sickle cell screen should be referred to their medical provider further evaluation and treatment services.

There is no single treatment of all people with SCD. Treatment options differ depending on the presenting symptoms. This can range from increased water intake to use of over the counter pain medication to blood transfusions or bone marrow transplant. **(See *Appendix E: Center for Disease Control and Prevention: Facts About Sickle Cell Disease*)**. NMDOH does not provide preventive treatment for any symptoms or complications associated with sickle cell disease. See Section 3 for vaccination services provided by NMDOH.

People with SCD can take precautions to minimize the risk of acquiring complications associated with sickle cell disease. The Centers for Disease Control and Prevention recommends the following activities:

- Obtain quality medical care from providers who are knowledgeable about SCD, such as a hematologist;
- Get regular check-ups. Babies from birth to 1 year of age should see a doctor every 2-3 months; children from 1 – 2 years should see a doctor at least every 3 months; children and adults over the age of 2 years should see a doctor at least once every year;
- Prevent infections – Babies and children with SCD should receive all ACIP recommended immunizations as well as immunization against influenza and pneumococcal viruses. Meningococcal vaccine may be recommended by the medical provider. Adults should receive annual influenza and pneumococcal immunizations. In addition, children with SCD should receive a daily dose of penicillin, to help prevent infections;
- Learn Healthy Habits – People with SDC should drink 8-10 glasses of water each day and eat a healthy diet. Persons should also refrain from temperatures that are too cold or too hot. Regular exercise and adequate rest are also important;
- Get Support – Contact local or national Sickle Cell Disease organizations to learn more about the disease and connect with others who share similar experiences. Contact information is listed below:
    - University of New Mexico Children's Hospital
      Division of Hematology/Oncology
      2211 Lomas Blvd, NE
      Albuquerque, NM 87106
      Pediatric Care
      Phone: (505) 272-4461

    - Sickle Cell Council of New Mexico, Inc.
      1330 San Pedro NE, Suite #201A
      Albuquerque, NM 87110
      Phone: (505) 254-9550 or (877) 471-6796
      http://www.sicklecellnm.org/

SECTION 12 STANDING ORDERS FOR TUBERCULOSIS SCREENING

Description of Condition
All refugees receive an overseas medical examination prior to their departure for the U.S. This examination is to identify individuals with conditions that, by law, necessitate exclusion from, or treatment before departure for, the U.S. Pre-departure information regarding screening, chest x-ray, diagnostic results, treatment, and clinical course is included in the refugee's overseas medical forms. Refer to the NMDOH PHD Targeted Testing, Diagnosing and Treatment of Latent Tuberculosis Infection that is located in the clinical protocols section of the PHD Intranet for specific guidance regarding testing, treatment and follow-up services (http://intranet/PHD/documents/LIBIProtocol2012-.PDF).

Clinical Assessment
All refugees should be screened for TB regardless of overseas medical history. Order PA and Lateral chest x-ray for all patients with a positive QFT or TST result.

- Refugees ≥ 15 years of age
  - Provide a QuantiFERON TB-Gold In-Tube test (See NM DOH PHD standard operating procedures for QuantiFERON tests)
  - Provide Complete Blood Count (CBC) with differential and Comprehensive Metabolic Profile (CMP) tests.
- Refugees < 15 years of age
  - Client ≥ 5 years of age: Refer for QuantiFERON TB In-Tube test.
  - Client birth through 5 years of age: Place a Mantoux skin test (TST). Read within 48-72 hours. A negative TST should be considered unreliable in infants < 3 months and should be repeated when the infant is greater than 3 months of age. However, a positive TST result in this age group should be considered reliable.
- Contact the Refugee Health Program Manager if the refugee does not have copies of their overseas medical evaluation forms.

Normal and Abnormal Findings
See Methodology Section on page 7 of the Refugee Health Protocol and Standing Orders for Public Health Nurses for reporting for guidance regarding abnormal test values and reporting of laboratory results. **Note: A skin test ≥ 5mm is counted as positive because this is a high-risk population.**

Follow-up and Evaluation for Treatment and Care

- Complete the TB Record 001 for clients with positive QFT results
- Follow TB protocol for appropriate treatment of TB infection http://intranet/PHD/documents/LIBIProtocol2012-.PDF).
- Contact the TB Nurse Consultants at the Central Office prior to referral to the TB Medical Director or if you have any questions regarding screening or who should be started on treatment

- Provide client education regarding the test results and ways to minimize transmission of TB infection

SECTION 13 STANDING ORDERS FOR ASSESSMENT AND REFERRAL FOR OTHER HEALTH CONDITIONS

Description of Condition
Common health problems of refugees include hematological disorders (eosinophilia, anemia, and microcytosis), hypertension, dental carries, nutritional deficiencies, and ophthalmologic problems.

Follow-up and Evaluation for Treatment and Care
If history suggests these, work with the VOLAG case manager to assure client promptly makes and keeps an appointment with PCP. Refer all refugees to a primary care and dental provider to establish a medical home and address overall health needs.

References

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Appendix A: NMDOH Refugee Health Domestic Screening Guidelines

Activity	Adults (Test Provided by PHO)	Children < 15 years refer to approved lab for blood draw
History & Physical Exam		
History (includes review of overseas medical exam)	Overseas medical records and other available medical records should be reviewed for all newly-arrived refugees.	
Physical Exam & Review of Systems (includes mental health, dental, hearing, and vision screening; nutritional, reproductive assessment; health education and anticipatory guidance, etc.)	All refugees should be referred to a primary care provider or specialty care for hematological disorders, hypertension, dental caries, nutritional deficiencies, and ophthalmologic problems	
Laboratory Tests		
Blood Lead Level	Individuals 16 - 18 years of age	Children 6 months to 15 years of age. Children < 6 years: refer for second lead screen 6 months after the initial screening
Chlamydia/Gonorrhea Testing	Individuals ≥ 15 years of age, regardless of reported risk factor	Children < 15 years who are sexually active, have a history of sexual abuse, or other risk factors
Cholestrol	In accordance with US Preventative Services Task Force guidelines	
Complete Blood Count with Diff.	Individuals ≥ 15 years of age	Individuals < 15 years of age
Complete Metabolic Panel	Individuals ≥ 15 years of age	Individuals < 15 years of age
Hepatitis B Testing	Individuals ≥ 15 years: Hepatitis B surface antigen (HBsAg); Hepatitis B surface antibody (Anti-HBs); Hepatitis B core antibody, total (Anti-HBc); and Hepatitis B core IgM antibody (Anti-HBc IgM)	Children > 15 months and < 15 years of age
Hepatitis C Testing	Individuals with risk factors (e.g., history of IDU, sharing of glass pipes for smoking crack or meth; sharing intranasal inhalant equipment; overseas blood transfusions; HIV positive; body art obtained in unsterile conditions)	Children with risk factors (e.g., hepatitis C positive mothers; blood transfusions; body art obtained in unsterile conditions)
HIV Testing	Refugees ≥ 15 years regardless of reported risk factor; use opt-out approach	Refugees < 15 years regardless of reported risk factor; refer to lab for testing
Pregnancy Test	Women of childbearing age: use opt-out approach	Girls of childbearing age: use opt-out approach or with consent from guardian. In office test.
Syphilis Testing	Individuals ≥ 15 years of age regardless of reported risk factors or overseas medical history	Children < 15 years with family member with positive syphilis diagnosis, history of sexual abuse, or other risk factors
Syphilis Confirmation Test	Individual with positive VDRL or RPR test	Children with positive VDRL or RPR test
Urinalysis	Refer to PCP for testing	

NMDOH/PHD/IDB/ Refugee Health Screening Protocol and Standing Orders for PHD Nurses/
Revised December 2013

Appendix A: NMDOH Refugee Health Domestic Screening Guidelines

Activity	Adults (Test Provided by PHO)	Children < 15 years refer to approved lab for blood draw
Preventive Health Interventions & Other Screening Activities		
Immunizations	Individuals with incomplete or missing immunization records	Children with incomplete or missing immunization records
Intestinal Parasites	Individuals who did not complete pre-departure presumptive treatment. Currently, only refugees originating from Ethiopia, Kenya, Tanzania, Rwanda, South Africa, Uganda, Malaysia, Nepal, Thailand, Iraq, and Jordan are treated prior to arrival. Therefore, all refugees PLUS the groups mentioned who had contraindications at departure (e.g., pregnant) should be presumptively treated.	
Malaria Blood Smear	Individuals from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g. pregnant, lactating)	Children from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., < 5 kg)
Mental Health Screening	All individuals should receive mental health screen. Refer clients to the Refugee Health Mental Health Coordinator for comprehensive assessment or support services. The RMHC will facilitate appropriate referrals for treatment and follow-up services.	
Sickle Cell Index	Newly-arrived refugees ≥ 15 years from sub-Saharan Africa	Newly-arrived refugees > 6 months and < 15 years of age from sub-Saharan Africa
Tuberculosis Screening	All persons ≥ 15 years should receive QuantiFERON TB-Gold-In-Tube test. Order PA/Lateral chest x-ray if QFT is positive.	Children ≥ 6 years and < 15 years should receive QuantiFERON TB-Gold In-Tube test. Children birth through 5 years, place TST and read within 48-72 hours. Order PA/Lateral Chest x-ray for all positive QFT and for TST > 5mm. Negative TST is considered unreliable in infants < 3 months; a positive TST result in this age group should be considered reliable.

Appendix B: NMDOH Recommended Adult Testing and Immunization by Risk Groups

	TESTING Recommended			IMMUNIZATION Recommended		HBIG Recommended
Risk Group	HEP A	HEP B	HEP C	HEP A	HEP B	
Current IDU	No	Yes[1]	Yes	Yes	Yes[1]	No
Person who shares crack/meth pipes or intranasal inhalant equipment such as straws	No	Yes	Yes	Yes	Yes[1]	No
Former IDU	No	Yes	Yes	No	No	No
MSM or Bisexual male	No	No	No	Yes	Yes	No
Sexual contact of MSM or IDU	No	No	No	Yes	Yes	No
Hepatitis C Positive	No	Yes	—	Yes	Yes[2]	No
Hepatitis B Acute/Chronic Carrier	No	—	Yes	Yes	No	No
HIV Positive	No	Yes	Yes	Yes	Yes[3]	No
Blood transfusion or organ transplant before July 1992	No	No	Yes	No	No	No
Person from endemic area incl. Asia, Central and Eastern Europe, Sub-Saharan Africa	No	Yes	No	No	Yes[3]	No
Heterosexual with multiple sex partners (>1 in last 6 months)	No	No	No	No	Yes	No
Person seeking evaluation or treatment for an STD	No	No	No	No	Yes	No
CONTACTS- HEPATITIS B ACUTE CASES						
Sexual contact within last 14 days[4]	No	Yes[5]	No	No	Yes[4]	Yes[4]
Household contact, no known exposure[6]	No	No	No	No	Yes	No
Household contact, known exposure (e.g. shared toothbrush or razor)	No	Yes	No	No	Yes[4]	Yes[4]
Injection partner contact within last 14 days	FOLLOW RISK GROUP "CURRENT IDU" above					Yes
CONTACTS – HEPATITIS B CHRONIC CASES						
Sexual contact of chronic case of HBV	No	Yes	No	No	Yes[3]	No
Household contact of chronic case of HBV	No	Yes	No	No	Yes[3]	No
Injection partner contact	FOLLOW RISK GROUP "CURRENT IDU" above					
CONTACTS – HEPATITIS C CHRONIC CASES Follow Risk Group recommendations above.						
CONTACTS – HEPATITIS C ACUTE CASES Follow Risk Group recommendations above. If no exposure report other than sexual exposure, consider testing recent (within past 6 months) sexual partners to identify potential infected source person(s).						

1. Current IDU/Persons who share glass pipes or inhalant equipment: Test and give first doses of hep A and hep B vaccine. Follow up with subsequent doses if susceptible.
2. If client is a current IDU, follow "Current IDU" testing recommendations. If non-IDU, vaccinate if susceptible.
3. If susceptible.
4. After blood draw for HBV serology, a single dose of HBIG (0.06ml/kg) should be given if contact was within 14 days. Begin the hepatitis B vaccine series at the same time at a different anatomical site. Complete the series if contact is susceptible.
5. If initial serology is negative, titer should be repeated in 3 months.
6. If an unvaccinated or under-vaccinated infant <12 months of age is in a household where the primary caregiver has acute hepatitis B, the infant should receive HBIG and start or complete the hepatitis B vaccine series.

Appendix C: Interchangeability Schedule for Adult Twinrix and Adult Monovalent Hepatitis A and Hepatitis B Vaccine

Pre-visit immunity status of person >18 yrs	0 month	1 month	6 months	11-12 months
No hepatitis history	T	T	T	
No hepatitis history	A and B	B	A and B	
HAV exposure or completed Hep A series	B	B	B	
HAV exposure and 1 dose Hep B		B	B	
HAV exposure and 2 doses Hep B			B	
HBV exposure or completed Hep B series	A		A	
HBV exposure and 1 dose Hep A			A	
1 dose Hep A	B	B	A and B	
1 dose Hep A	B	B	T	A
2 doses Hep A	B	B	B	
1 dose Hep B	A	B	A and B	
1 dose Hep B		T	T	A
2 does Hep B	A		A and B	
2 doses Hep B	A		T	A
3 doses Hep B	A		A	
1 dose Hep A and 1 dose Hep B		B	A and B	
1 dose Hep A and 1 dose Hep B		B	T	T
2 doses Hep B and 1 dose Hep A			A and B	
2 doses Hep B and 1 dose Hep A			T	A
2 doses Hep B and 1 dose Twinrix			A	A
1 dose Twinrix		T	T	
1 dose Twinrix		B	A and B	A
2 doses Twinrix			T	
2 doses Twinrix			A and B	
1 dose Twinrix and 1 dose Hep A		B	A and B	
1 dose Twinrix and 1 dose Hep A		B	T	
1 dose Twinrix and 1 dose Hep B			A and B	A
1 doses Twinrix and 1 dose Hep B			T	T
1 dose Twinrix and 2 doses Hep B	A		A	
1 Twinrix and 1 Hep B and 1 Hep A			A and B	
1 Twinrix and 1 Hep B and 1 Hep A			T	

Legend

A Hepatitis A vaccine

B Hepatitis B vaccine

Acceptable dosing intervals

- Interval between 1st Twinrix dose and 3rd Twinrix dose should be at least 6 months
- Interval between 1st Twinrix dose and 2nd Twinrix dose should be at least 1 month
- Interval between 2nd Twinrix dose and 3rd Twinrix dose should be at least 2 months
- Recommended intervals for single antigen vaccines, when used in combination series that includes Twinrix, must still be observed.

Appendix D: Treatment Schedules for Presumptive Parasitic Infections for U.S.-Bound Refugees Administered by IOM – May 2013

Prepared by Immigrant, Refugee and Migrant Health Branch, Division of Global Migration and Quarantine, CDC

This table describes presumptive anti-parasitic treatment currently provided to the largest groups of U.S.-bound refugees. The first three columns list the region, departure country, and ethnicity/national origin of the refugees. The fourth column lists recommended presumptive treatment for parasites (including malaria).

Region	Country of Processing	Principal Refugee Groups (location)	Presumptive Parasite Treatment for Eligible Refugees[b,c]	Comments
Africa	Ethiopia	*Eritreans (Shimelba); Somalis (Kebribeya); Multiple (Addis Ababa)*	Albendazole Praziquantel Artemether-lumefantrine	Artemether-lumefantrine since Oct 2007
	Kenya	*Somalis (Dadaab); Somalis, Sudanese, Congolese (Kakuma); Multiple (Nairobi)*	Albendazole Praziquantel Artemether-lumefantrine	Artemether-lumefantrine since fall 2007
	Tanzania	*Congolese, Burundians (Kigoma)*	Albendazole Praziquantel Artemether-lumefantrine	Artemether-lumefantrine since July 2007
	Rwanda, South Africa, Uganda	*Somalis, Congolese*	Albendazole Praziquantel Artemether-lumefantrine	
Asia	Malaysia	*Burmese (Kuala Lumpur)*	Albendazole Ivermectin	-Albendazole for children 1-2 yo since Nov 2011 -Ivermectin, since Feb 2013
	Nepal	*Bhutanese (Beldangi, Sanischare, Khudunabari); other (urban)*	Albendazole Ivermectin	-Albendazole for children 1-2 yo since Feb 2012 -Ivermectin since Jan 2013
	Thailand	*Burmese (Thailand-Burma border); other (urban)*	Albendazole Ivermectin	-Albendazole for children 1-2 yo since Oct 2011 -Ivermectin since July 2011
Mideast	Iraq	*Iraqis (Baghdad, Al Walid camp)*	Albendazole	
	Jordan	*Iraqis (Amman)*	Albendazole	
	Lebanon, Syria, Turkey, Egypt	*Multiple*	None	
Europe	Russia, Ukraine, Moldova	*Russians, Afghanis, Ukrainians, Moldovans*	None	
Americas	Cuba, other	*Cubans, Colombians*	None	

a Information provided by the International Organization for Migration (IOM) during required overseas refugee medical exam
b Presumptive parasite treatments: Albendazole (for soil-transmitted helminths), 400 mg for refugees ≥ 2 yo, Albendazole, 200 mg for those 1-2 yo; Ivermectin (for strongyloides), 200 µg/kg x 2 d, and Praziquantel (for schistosomiasis), 40 mg/kg divided in 2 doses. See http://www.cdc.gov/immigrantrefugeehealth/guidance/overseas/intestinal-parasites-overseas.html
Artemether-lumefantrine (AL, for malaria) 6-dose treatment. See http://www.cdc.gov/immigrantrefugeehealth/guidance/overseas/malaria-guidance-overseas.html#top)
c Over 75% compliance rates with administration of presumptive parasite treatment have been documented for the countries listed on this table. If a country does not appear on this table, then compliance rates in that country are uncertain, so clinicians should use their judgment on a screening vs. presumptive treatment approach

Appendix E:

What You Should Know About Sickle Cell Disease

What Is Sickle Cell Disease?

Sickle cell disease (SCD) is a group of inherited red blood cell disorders.

- Healthy red blood cells are round and they move through small blood vessels carrying oxygen to all parts of the body.
- In SCD, the red blood cells become hard and sticky and look like a C-shaped farm tool called a "sickle".
- Sickle cells die early, which causes a constant shortage of red blood cells.
- Sickle cells can get stuck in small blood vessels and block the flow of blood and oxygen to organs in the body. These blockages cause repeated episodes of severe pain, organ damage, serious infections, or even stroke.

What Causes Sickle Cell Disease?

SCD is inherited in the same way that people get the color of their eyes, skin, and hair.

- A person with SCD is born with it.
- People cannot catch SCD from being around a person who has it.

Who Is Affected By Sickle Cell Disease?

- It is estimated that SCD affects 90,000 to 100,000 people in the United States, mainly Blacks or African Americans.
- The disease occurs among about 1 of every 500 Black or African-American births and among about 1 out of every 36,000 Hispanic-American births.
- SCD affects millions of people throughout the world and is particularly common among those whose ancestors come from sub-Saharan Africa; regions in the Western Hemisphere (South America, the Caribbean, and Central America); Saudi Arabia; India; and Mediterranean countries such as Turkey, Greece, and Italy.

What Health Problems Does Sickle Cell Disease Cause?

Following are some of the most common complications of SCD:

"Pain Episode" or "Crisis": Sickle cells don't move easily through small blood vessels and can get stuck and clog blood flow. This causes pain that can start suddenly, be mild to severe, and last for any length of time.

Infection: People with SCD, especially infants and children, are more likely to experience harmful infections such as flu, meningitis, and hepatitis.

Hand-Foot Syndrome: Swelling in the hands and feet, often along with a fever, is caused by the sickle cells getting stuck in the blood vessels and blocking the blood from flowing freely through the hands and feet.

Eye Disease: SCD can affect the blood vessels in the eye and lead to long term damage.

Acute Chest Syndrome (ACS): Blockage of the flow of blood to the lungs can cause acute chest syndrome. ACS is similar to pneumonia; symptoms include chest pain, coughing, difficulty breathing, and fever. It can be life threatening and should be treated in a hospital.

Stroke: Sickle cells can clog blood flow to the brain and cause a stroke. A stroke can result in lifelong disabilities and learning problems.

National Center on Birth Defects and Developmental Disorders
Division of Blood Disorders

CDC

CS314078

How Is Sickle Cell Disease Treated?

The goals of treating SCD are to relieve pain and to prevent infections, eye damage, and strokes.

- There is no single best treatment for all people with SCD. Treatment options are different for each person depending on the symptoms. Treatments can include receiving blood transfusions, maintaining a high fluid intake (drinking 8 to 10 glasses of water each day), receiving IV (intravenous) therapy (fluids given into a vein) and medications to help with pain.
- For severe SCD, a medicine call hydroxyurea might be recommended. Research suggests that hydroxyurea can reduce the number of painful episodes and the recurrence of ACS. It also can reduce hospital stays and the need for blood transfusions among adults who have SCD.

Is There A Cure For Sickle Cell Disease?

To date, the only cure for SCD is a bone marrow or stem cell transplant.

- A bone marrow or stem cell transplant is a procedure that takes healthy stem cells from a donor and puts them into someone whose bone marrow is not working properly. These healthy stem cells cause the bone marrow to make new healthy cells.
- Bone marrow or stem cell transplants are very risky, and can have serious side effects, including death. For the transplant to work, the bone marrow must be a close match.

For more information visit: www.cdc.gov/sicklecell

PUBLIC HEALTH DIVISION
CLINICAL PROTOCOL/MANUAL APPROVAL SHEET

PROGRAM/BUREAU: Refugee Health Program/ Infectious Disease Bureau

CLINICAL PROTOCOL/MANUAL TITLE: Refugee Health Protocol and Standing Orders for Public Health Division Nurses

Reviewed by: **(Must have a signature from at least one clinical user of the Clinical Protocol.)**

Approved by:	Signature	Date
IDB Medical Director		1/10/14
PHD Medical Director	Maggi Hall	12/20/13
NW/Metro Regional Health Officer	Maggi Hall	12/20/13

Reviewed by	Signature	Date
Refugee Health Program Manager	Karen L Gonzales	12/20/13
Infectious Disease Bureau Chief	Marie Gh	1/9/14
PHD Chief Nurse		1/6/14
Clinical End User		1/10/14

Refugee Health Screening Related Costs

Exam Activity	Cost
Physical Exam & Review of Systems	$20.25
Complete Blood Count with Differential	$10.69
Complete metabolic panel	$14.53
Serum Chemistries	$15.44
Urinalysis	$3.74
Pregnancy Testing	$8.70
HIV Testing (opt-out approach)	$14.52
Hepatitis B Testing:	
Hep Surface Antigan	$14.20
Hep B Surface Antibody	$14.76
Hep B Core Antibody, Igm	$16.18
Hep B Core Antibody, total	$16.57
Hepatitis C Testing:	
HCV antibody	$18.29
Syphilis Testing	$5.87
Chlamydia/Gonorrhea Testing	$71.60
Tuberculosis Screening	$85.20
Malaria blood smear	$12.80
Sickle Cell Index	$7.59

Vaccination	Cost Per Series
Pneumovax	$65.77
MMRII	$94.14
Tdap	$33.35
HPV	$144.93
Td	$39.86
Zostavax	$201.88
Varacella	$163.64
Hepatitis B	$179.13
Hepatitis A	$101.86
Twinrix	$339.84