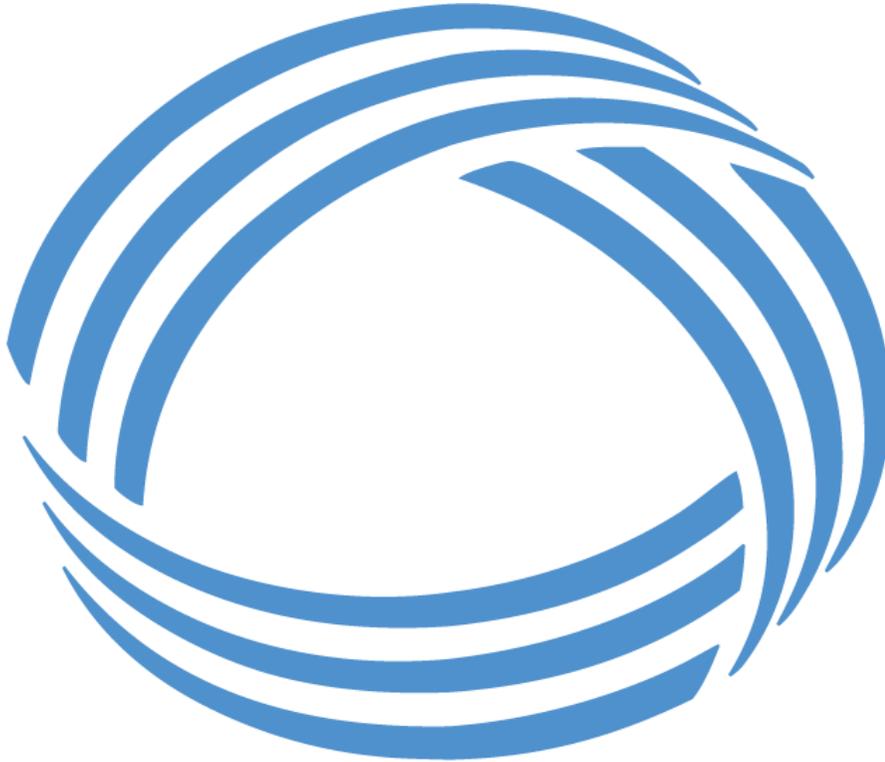


PART II

POLICIES AND PROCEDURES AFFORDABLE CARE ACT FOR PRESUMPTIVE ELIGIBILITY PREGNANT WOMEN MEDICAID



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Part II Policies and Procedures Manual for Presumptive Eligibility 2016

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
1/1/2016	Cover Page	Revisions to Cover Page Template	M	
4/1/2016	Sec 602 –V1-2	PGW 2016 FPL Increase	M	
7/1/2016	602 – VI-2	Added statement about RSDI for tax dependent/child	A	
7/1/2016	Appendix E - Examples	Example of RSDI for tax dependent/child	A	
7/1/2016	Appendix I - Income	Updated Appendix I-Treatment of Income	A	
7/1/2016	Appendix M – MEMO	Added MEMO dated August 21, 2014 regarding RSDI of Tax Dependents for MAGI based Medicaid and PeachCare for Kids determinations	A	

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AFFORDABLE CARE ACT
FOR PRESUMPTIVE ELIGIBILITY PREGNANT
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CHAPTER 100 INTRODUCTION

101 Goal of Presumptive Eligibility (PE)

The goal of the Presumptive Eligibility (PE) program is to provide Medicaid coverage during the application processing period and remove barriers to the availability of prenatal care critical in positively affecting the birth outcome and the health of the mother.

The Department of Community Health (DCH) is committed to providing the individuals responsible for determining a pregnant woman's PE with clear and practical guidelines to:

- Understand Medicaid coverage available to pregnant women.
- Understand the application process for PE.
- Understand the eligibility requirements to be used in making PE determinations.
- Be able to compute a PE budget using a PE pregnancy application form **DMA** 632.
- To screen on Georgia Medicaid Management Information System (GAMMIS) to prevent multiple Member ID numbers being issued.
- To correctly perform on-line entry of the **approved** PE application.
- Understand procedures for processing **PE** applications.

CHAPTER 200 OVERVIEW OF PRESUMPTIVE ELIGIBILITY

201 Definition and Description of Presumptive Eligibility (PE) Option

§435.907 Application/SPA S28-2; S28-3; S28-4; S94-1

The federal legislation, which gives states the authority to cover pregnant women, infants and children under federal poverty level income limits, also contains a provision for providing ambulatory prenatal care to pregnant women during the time period that a formal Medicaid application is pending with the eligibility agency. Beginning January 1, 1993, the Division of Medical Assistance (DMA), a division within the Department of Community Health (DCH), implemented this Presumptive Eligibility (PE) program for pregnant women.

PE is a determination performed by the Qualified Provider (QP)/Qualified Hospital (QH). Coverage is available prior to a formal determination of eligibility by the local Right from the Start Medicaid (RSM) Project or the county Division of Family and Children Services (DFCS).

PE is an expedited process of enrolling eligible pregnant applicants in the Medicaid program. It allows certain providers, designated as Qualified Provider (QP)/Qualified Hospital (QH), to make a preliminary Medicaid eligibility determination on behalf of a pregnant applicant. Medicaid coverage may be granted to the pregnant applicant whose net taxable income does not exceed 220% of the federal poverty level. PE consists of an income comparison test using the applicant's statements to establish gross taxable income and pregnancy.

PE period begins on the day of the month in which the QP/QH determines the applicant eligible. PE ends when RSM or DFCS determines eligibility or ineligibility for Medicaid, but no later than at the end of the following month of the PE approval. PE Medicaid does not cover inpatient hospital and delivery services only ambulatory prenatal care services are covered during the presumptive period.

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The PE period begins on the date the Qualified Provider/Qualified Hospital determines the applicant eligible. PE period ends when RSM/DFCS determines eligibility or ineligibility for Medicaid, but no later than at the end of the following the month of the PE approval. *The web portal has been updated and coverage no longer reverts to the beginning of the month for Presumptive Eligibility.

If the applicant is determined eligible for the program, she receives a temporary Medicaid certificate her first month of eligibility. If the eligibility continues, she receives the plastic Medicaid member identification card for newly approved beneficiaries. If a beneficiary was previously issued a Medicaid member identification card, she will not automatically be mailed a replacement card. Replacement cards are requested by the beneficiary via online through GAMMIS or by calling HP at 1-866-211-0950.

This number will remain the same throughout the member's eligibility

These temporary Medicaid benefits are available only to applicants that state they are pregnant. PE determinations can be completed by QP/QH only. RSM and DFCS are not included in the legislation as qualified providers/qualified hospitals; the regulations do not allow all providers to be certified as qualified providers/qualified hospitals.

After the PE process is completed, the QP/QH will obtain a signed, Health Coverage Medicaid application (per the applicant's request); a declaration of citizenship/qualified immigrant form; and a HIPAA form 5460. These forms, along with a copy of the PE application form DMA 632, will be forwarded to the local RSM/ DFCS office for a formal determination of Medicaid eligibility. Procedures for routing forms and communicating information between the QP/QH and the local RSM or DFCS office should be worked out at the county level.

The completed PE Pregnant Women Medicaid packet must be received at the RSM/ DFCS office within five (5) working days after the PE application is taken. If at all possible, the application package should be forwarded to the RSM/ DFCS office daily to assure a fast turnaround on the formal application. The later in the pregnancy the beneficiary is, the more critical expedient application processing becomes.

202 Summary of Process

The PE process involves the Qualified Provider (QP) or the Qualified Hospital (QH), the Department of Community Health (DCH), the Georgia Medicaid Management Information System (GAMMIS), and the county Division of Family and Children Services (DFCS) or Right from the Start Medicaid (RSM) Project. The QP/QH determines eligibility for the presumptive period, the county DFCS office or local RSM outreach worker determines eligibility for ongoing and retroactive Medicaid and DCH/GAMMIS issues the Medicaid member **identification** card, thereby, providing reimbursement to participating providers for Medicaid approved services.

The process begins when the applicant enters the QP's/QH's office and requests Medicaid coverage. The QP/QH obtains enough information to determine income and pregnancy eligibility based on the applicant's statements. After the PE **Pregnant Women Medicaid** determination is completed, the QP/QH assists the applicant with the **Health Coverage** application form 94A for ongoing and retroactive Medicaid eligibility at the applicant's request.

After the PE **Pregnant Women** Medicaid is approved, the **beneficiary** is given a temporary Medicaid certificate. The QP/QH sends the completed PE **Pregnant Women Medicaid** packet to the local RSM/**DFCS** office. Upon receipt of the PE package, the local DFCS or RSM office registers the Medicaid application, if completed by the applicant, and determines eligibility for ongoing months, as well as, the retroactive months. Notice is given to the **beneficiary** regarding the eligibility finding, and the results of the determination are forwarded to the DCH/GAMMIS for appropriate processing.

When DCH/GAMMIS receives the eligibility information, an open record is established on the history file (member data base) for payment of claims. When the DCH/GAMMIS is notified by the local **RSM**/DFCS office of the results of the Medicaid determination, the record is continued as an active Medicaid record if eligible or closed if ineligible. Subsequent changes of address should be reported by the **beneficiary** to the DFCS Call Center 1-877-423-4746. Loss of their Medicaid card and/or change of address should be reported by the **beneficiary** to the HP Member Contact Center at 1-866-211-0950.

203 Certification Process and Liability

Providers who meet the requirements of participation will be given the opportunity to become Qualified Providers (QP)/Qualified Hospital (QH). The training requirement is met by attending a presumptive workshop and satisfactorily performing the training exercises.

Upon completion of the training, each provider certifies that all QP/QH requirements have been met by completing the QP/QH enrollment form. Upon receipt of the enrollment form, the DCH Provider Enrollment Unit will add the QP/QH specialty code to the provider's file and issue an approval notice to the provider showing the effective begin date for performing QP/QH activities.

A provider interested in becoming a QP should contact:

HP Provider Enrollment
P.O. Box 105201
Tucker, GA 30085-5201

Call toll free 1-800-766-4456 or on line at www.mmis.georgia.gov

Enrollment Wizard

Providers use this page to complete an enrollment application to become a participating provider in the Georgia Medicaid program. The application uses a wizard to guide applicants through the enrollment form. An in-progress application can be saved and completed at a later time.

Please reference the [Part I, Policies and Procedures for Medicaid/PeachCare for Kids®](#) manual, for general requirements that apply to all provider types when enrolling as a Georgia Medicaid provider. Applicants must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Specific qualifications for each provider type are contained in chapter 600 of the program specific policy manual(s).

The Enrollment Wizard will assist with the completion of an application. Required documents, as stipulated in the applicable policy manual sections, may be uploaded with the application.

A scanned or faxed copy of the Power of Attorney for Payee will be accepted providing that:

1. The submitted Power of Attorney for Payee reflects the raised notary seal and all signatures can clearly be seen via a scanned or faxed copy.
2. If the notary seal is an ink seal it can be clearly seen via a scanned or faxed copy.
3. If the notary seal and all signatures are unclear or illegible when the document is scanned or faxed, the faxed or scanned Power of Attorney for Payee will be returned to the sender and an original Power of Attorney for Payee will have to be submitted.

The Department reserves the right to reject a scanned or faxed copy of a Power of Attorney for Payee.

To begin, click on the Provider Enrollment Application link below and provide the information requested. If you have any questions regarding completion of the wizard or status of an application, you may contact the Provider Enrollment Unit for assistance.

[Provider Enrollment Application](#)

204 Responsibilities of a Qualified Provider/Qualified Hospital

- Make correct determinations of PE;
- Notify county RSM/DFCS office and the DCH/GAMMIS within 5 working days of PE determination results (preference is daily);
- Inform the applicant in writing of the results of the PE determination;
- After the completion of the PE determination and requested by the applicant, obtains a signed Health Coverage application.

DCH Member Services and Policy Unit will be used in support of activities to provide follow-up training to providers who are in need of additional training. Additionally, these staff will review a sample of PE applications, form DMA 632, monthly to identify areas of the procedural process needing modification.

2015 PE Pregnancy VICS Training Schedule

New training schedule for 2016 to be announced.

You may contact pecorrections@dch.ga.gov if you have any additional questions about training.

All state QPs agencies such as Department of Public Health (DPH), Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) can contact their local DPH office to see if they can attend the VICS training at that office. QHs may also contact DPH to reserve seating for the VICS training.

All other QPs/QHs will need to email pecorrections@dch.ga.gov to make arrangements to attend the training at the DCH State office in Atlanta.

Participants should have PE Pregnant **Women Medicaid** knowledge before participating in training which includes, but not limited to:

- PE Pregnant **Women Medicaid** manual review
- PE Pregnant **Women Medicaid** forms review
- The PE Pregnant **Women Medicaid** process/procedures for your office
- Non-financial eligibility criteria (Citizenship/Immigration status; residency)
- Financial eligibility criteria (Taxable Income; deductions; FPL)
- Basic Budget Groups understanding
- Basic P4HB understanding

205 Services and Provider Population

PE provides Medicaid reimbursement for ambulatory prenatal care during the application processing period. Because a healthy outcome to pregnancy is affected by many factors including regular prenatal care and continuing good health of the pregnant woman; PE does not cover inpatient hospital and delivery services. Inpatient hospital services, and delivery procedures, are not included because they do not meet the definition of ambulatory **prenatal care** services as defined in the Medicaid state plan.

All limitations to services and other special requirements, such as prior approval, must be met for the service to be reimbursable. Claims must be submitted according to the directions of DCH policy within the time frames specified. Any questions regarding billing procedures should be directed to the DCH's fiscal agent, Hewlett Packard.

While only certain providers can be certified as Qualified Providers/Qualified Hospitals, any enrolled provider may render service and seek reimbursement from the Department of Community Health (DCH) approved services rendered during the PE period. By allowing all enrolled providers to give services during the PE period, the goal of improving health care availability is met.

CHAPTER 300 GENERAL PROGRAM REQUIREMENTS

301 Right to Apply

§435.906 Opportunity to apply.

Any applicant will be given the opportunity to apply for Medicaid benefits without delay.

A PE application may be made at any time during a pregnancy, even if there is a Medicaid application pending at the county DFCS office. However, a PE application cannot be taken after the pregnancy has ended.

If the applicant is already active on another Medicaid class of assistance (COA), inform the applicant she is already active. Refer her to her DFCS case manager to have her case updated with her pregnancy information. PE is a temporary Medicaid; therefore, do not complete a PE application when the applicant is already active on full Medicaid except for Planning for Healthy Babies (P4HB) aid categories 180-181, and any Q-Track aid category 660-662. Refer to appendix C for a brief overview of the COA.

If the **beneficiary** is active on Planning for Healthy Babies (P4HB) **180-181** complete the PE application and GAMMIS will update the system. Do not refer these beneficiaries back to DFCS.

If the **beneficiary** is active on Q-Track complete the PE application and GAMMIS will show the member as dually eligible. Do not refer these beneficiaries back to DFCS.

All other active Medicaid beneficiaries are to be referred back to DFCS with their pregnancy information; except for those beneficiaries receiving Women's Health Medicaid (WHM) aid category 245. Please contact MORROW directly regarding pregnancy either by fax 770 359 1813, or emailing at womenshealth@dch.ga.gov

PeachCare for Kids® beneficiaries are not automatically given PE Medicaid when she states she is pregnant under the Affordable Care Act (ACA). When they remain PeachCare for Kids® eligible they need to report their pregnancy to PeachCare for Kids® at 877-GA-PEACH (877-427-3224).

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The applicant is the primary source of information regarding PE. The QP/QH will make the determination of eligibility based solely on the information obtained in the interview and will not require any verification or documentation of the applicant's statements. The applicant's statement regarding pregnancy is all that is required, medical verification of pregnancy is not. Under the Affordable Care Act (ACA) medical verification cannot be required prior to processing the PE application.

PE policy does not allow for Emergency Medical Assistance (EMA) to be approved as PE. An applicant may not be screened out if they are not a United States citizen; have not been naturalized; have not resided in the United States for at least 5 years per the Department of Homeland Security (DHS). These applicants will be given an application form **DMA** 632 and informed that their PE application will be denied initially; however, the **Health Coverage** application (if completed) will be reviewed by the RSM/DFCS team and the applicant will be notified of the final disposition of the Medicaid application for EMA.

302 Confidentiality

Any information regarding the applicant, obtained for the purpose of determining PE, is considered confidential, including the name, address and benefits provided, and may not be disclosed to any persons or agencies other than those directly related to the administration of Medicaid known as covered entities.

DCH, RSM/**MORROW**, DFCS, QP/QH and MAXIMUS are covered entities.

Who is affected by HIPAA?

If you answer **yes** to the questions below, you are a covered entity and are required to be HIPAA compliant:

- Are you a health plan or health care clearinghouse?
- Are you a health care provider who sends or receives health information (such as claims, remittance advice, eligibility, claim status, prior authorization, enrollment, premium payment or coordination of benefits) electronically?
- Do you store, have access to or maintain health information?

More information on covered entities can be found at:

<http://www.cms.gov/HIPAAGenInfo/Downloads/CoveredEntitycharts.pdf>

Health Information Portability and Accountability Act (HIPAA, [Public Law 104-191](#)) and safeguarding Protected Health Information (PHI) must be enforced at all times.

Covered entities may use and share only the minimum amount of protected information necessary to accomplish a particular purpose.

The minimum necessary standard, a key protection of the HIPAA Privacy Rule, is based on protected health information will not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.

The Privacy Rule requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. The minimum necessary standard does not apply to the following:

- Disclosures to or requests by a health care provider for treatment purposes.
- Disclosures to the individual who is the subject of the information.
- Uses or disclosures made pursuant to an individual's authorization.
- Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules.
- Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes.
- Uses or disclosures that are required by other law.

Each applicant will receive the Notice of Privacy Practices Form 5460.

HIPAA resource information can be found at: <http://dch.georgia.gov/hipaa-privacy-notices>

303 Non-Discrimination

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age of Discrimination Act of 1975 prohibit discrimination on the grounds of race, color, sex, age, religion, national origin, political affiliation or handicap in the administration of federally funded programs, including the Medicaid program.

The Department of Community Health (DCH) does not allow any applicant to be denied PE subjected to discrimination.

304 Notice and Informing

§435.913 Notice of agency's decision concerning eligibility.

An applicant is entitled to adequate notice of the results of the PE determination. She must receive notice that her Health Coverage application has been forwarded to the county DFCS/RSM office for a formal determination of eligibility when the applicant request to complete the Health Coverage application after the PE determination was completed.

Follow the process lined out in Chapter 700 and Appendix F for approvals or denials.

305 Fair Hearing Rights

§431.205 Provision of hearing system.

An applicant is entitled to a fair hearing when the county DFCS/RSM office makes a decision on her application for Medicaid benefits.

PE is a temporary time limited Medicaid coverage, there are no hearing rights available at the time of the determination of PE or at the time the PE coverage ends.

Per the Affordable Care Act (ACA), a pregnant applicant may only be determined PE Pregnant Women Medicaid eligible once per the same pregnancy. If the applicant has already been determined eligible for PE Pregnant Women Medicaid during her same pregnancy, the QP/QH must deny the new PE Pregnant Women Medicaid application and forward the PE Pregnant Women Packet to RSM/DFCS. QP/QH are to notify DCH of the beneficiaries that were medically verified to not be pregnant after the PE approval by forwarding the entire PE Pregnant Women Packet by email only to pecorrections@dch.ga.gov.

307 Planning for Healthy Babies (P4HB)

The Planning for Healthy Babies (P4HB) waiver covers Family Planning services to women ages 18 through 44 who are at or below 200 percent of the federal poverty level (FPL), who are not covered by insurance including Medicare and not otherwise receiving benefits under another Medicaid program. P4HB covers Inter-Pregnancy Care (IPC) services, including primary care case management, for eligible women who have delivered a very low birth weight baby (VLBW). Women, actively receiving Medicaid, that have delivered a very low birth weight baby, may receive services in the Resource Mother component of P4HB. P4HB is a three year term demonstration waiver that began on January 1, 2011.

The primary goals of the P4HB program are to reduce: Georgia's low birth weight (birth weight less than 2500 grams) and very low birth weight (birth weight less than 1500 grams) rates; the number of unintended and high risk pregnancies in Georgia; and Georgia's Medicaid costs by reducing the number of unintended pregnancies.

There are three levels of service under P4HB – Family Planning Services, Inter-Pregnancy Care Services, and Resource Mother Services.

See P4HB MEMO in Appendix M, and P4HB application, post card and poster located in Appendix R.

All applicants for PE should be informed about P4HB regardless if they are approved or denied.

On October 4, 2011 the P4HB program vendor implemented the new citizenship and identity verification process. This new process is a result of the amended Social Security Act allowing applicants declaring to be U.S. citizens or nationals to use this process in lieu of requiring the applicant to present satisfactory documentary evidence of citizenship/nationality and identity as specified in §435.407. The act provides the utilization of the State Verification Exchange System (SVES). SVES allows a State to submit to the Social Security Administration (SSA) an applicant's name, Social Security Number (SSN), and date of birth (DOB) for comparison with information that SSA has in its Master file of SSN Holders (Numident). A response from SSA that confirms the data submitted by the State is

consistent with the SSA data, including citizenship or nationality, meets the citizenship and identity verification requirements.

Effective October 2012, DFCS implemented the use of SVES.

AUTO ENROLLMENT

Effective November 2011, Medicaid women beneficiaries who meet the IPC component of P4HB eligibility requirements, but their Medicaid eligibility ends at the end of the current month, will be auto enrolled into the IPC P4HB the first of the following month. A letter explaining the IPC P4HB program; explaining the option of not being auto enrolled; informing the beneficiary they will keep their same Care Management Organization (CMO) but have an option to select a new CMO within thirty (30) days, will be mailed to the beneficiaries two to three (2-3) months prior to their scheduled Medicaid closure month.

Services for P4HB do not begin until the member is enrolled in a CMO; the CMO is listed as Managed Care Health Babies (MCHB) on the web portal.

All beneficiaries should be directed back to their MCHB for any questions regarding P4HB services.

DUALLY ELIGIBLE

When their PE or full Pregnancy Medicaid is approved the beneficiary will have two (2) aid categories active for the same eligibility span on GAMMIS; during this period the beneficiary is considered dually eligible.

Providers should file all PE related services claims as fee for service; do not file them with the MCHB listed. More information can be obtained from the HP Provider Contact Center and/or from the Provider Representatives at 1-800-766-4456.

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MATERIAL

Applicants will need to apply on line, www.p4hb.org, for P4HB if QP/QHs do not have any paper applications on hand. Applications, postcards and posters are no longer being printed for distribution.

CHAPTER 400 APPLICATION AND ENROLLMENT PROCESS

401 Procedural Responsibilities of Qualified Providers (QP)/Qualified Hospitals (QH) §435.1103 Presumptive eligibility for other individuals/SPA S94-1; S28-1; S28-2; S28-3; S28-4

The PE process involves several steps from the point of application with the QP/QH through the final disposition of the applicant's **Health Coverage** application by the DFCS/RSM county office.

1. The QP/QH shall conduct an interview with the applicant at which time the provider shall:
 - ❖ advise the applicant she may be eligible for Medicaid benefits as a presumptively eligible pregnant woman and for ongoing and retroactive Pregnancy Medicaid coverage;
 - ❖ obtain adequate information from the applicant to complete the PE application form DMA 632, the declaration of citizenship (form 216 or included in form 94A), and the HIPAA form 5460;
 - ❖ determine if the applicant meets the PE eligibility criteria; statement of income and pregnancy are accepted verification is not to be requested.
2. For any applicant determined **presumptively eligible**, the QP/QH shall:
 - perform on-line entry of the application, or forward a copy of the completed PE application form DMA 632 to HP the same day the PE application was completed, for data entry when a QP/QH does not have internet access to GAMMIS;
 - provide a temporary Medicaid certification, or form DMA 634 Approval Notice of Action if the certificate cannot be printed;
 - inform the **beneficiary** of the PE time limit and the services covered;
 - provide the **beneficiary** with a copy of the Medicaid Guide and fact sheet, "Quick Guide on Medicaid for Pregnant Women", which explains the program and covered services;

- Inform the **beneficiary** about Planning for Healthy Babies (P4HB);
- Give the **beneficiary** a copy of the Understanding Medicaid Booklet;
- Assist the **beneficiary** with completing the **Health Coverage** application and obtain the applicant's signature. If the **beneficiary** has proof of identity and/or citizenship/**immigration status** obtain a copy for the **Health Coverage** application. Write "viewed and copied" on each copy, stickers may be used. Refer to section 502 for the complete list of acceptable identity and/or citizenship/**immigration** documents.

NOTE: The only part of the **Health Coverage** application that is required after the completion of a PE application is the applicant's name, contact information, and sign and date the application **form 94A**. All other information was obtained during the PE application process and any other information needed will be obtained during the post eligibility process by RSM/DFCS. The **Health Coverage** application is the point the applicant can request any prior month(s) coverage.

- provide the **beneficiary** with the address and telephone number of the local RSM/DFCS office where her application has been sent;
- forward a copy of the completed PE application form DMA 632, the signed, **Health Coverage** application **form 94A** (if completed), Declaration of Citizenship/Immigration Status **included in form 94A**, form 5460 HIPAA to the local RSM/DFCS within five (5) working days, or sooner, if possible.

3. For any applicant determined **not eligible for presumptive** coverage, the QP/QH shall:

- ✓ inform the applicant verbally and in writing via form DMA 634 Denial that she is not presumptively eligible;
- ✓ advise the applicant that if her circumstances change, she may have another determination of PE performed by a QP;
- ✓ inform the applicant that her application for **Health Coverage** has been forwarded to the local RSM/DFCS office for a formal determination of eligibility (if completed);

- ✓ forward a copy of the completed PE application form DMA 632, the signed, **Health Coverage application form 94A** (if completed), Declaration of Citizenship/Immigration Status **included in form 94A**, form 5460 HIPAA to the local RSM/DFCS within five (5) working days, or sooner, if possible.
- ✓ provide the applicant with the address and telephone number of her local RSM/DFCS office;
- inform the applicant about Planning for Healthy Babies (P4HB);

APPROVED PE BENEFICIARIES REPORTED CHANGES

For any certified presumptively eligible beneficiary who reports a change of address, the QP/QH shall:

- advise the beneficiary to contact the **DFCS Call Center** (1-877-423-4746) **OR** report all changes at www.compass.ga.gov

For any certified presumptively eligible beneficiary who reports a lost/stolen card and/or a change of address, the QP/QH shall:

- advise the beneficiary to contact **HP Contact Center** (1-866-211-0950)

Correct addresses are needed so beneficiaries can obtain Medicaid notifications, Medicaid cards, their Care Management Organization (CMO) choice selection and ongoing information, and for NET (non-emergency transportation), etc.

The reported change information is included in the Quick Guide form to be given to all approved PE applicants. QP/QH should clearly go over this information.

Approved PE beneficiaries will be required to choose a CMO (WellCare, Amerigroup or Peach State). Inform them to talk to providers regarding which Medicaid they accept so they know which CMO to choose. The CMO information is included in the Quick Guide form to be given to all approved PE applicants. QP/QH should clearly go over this information.

CHAPTER 500 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

§435.603 Application of modified adjusted gross income (MAGI); §435.403 State residence/SPA S89-1; S89-2; S89-3; S28-3.

Non-income requirements for PE include the declaration of Citizenship/Immigration Status; Georgia Residency; and pregnancy statement.

In order to determine income eligibility for PE Medicaid coverage, it is necessary to determine who is included in the budget group. The budget group is comprised of those members of the household whose needs and net taxable income are included and compared to the net taxable income limit. The budget group size determines the income limit used and how much net taxable income is used in the comparison to the income limit.

All household members will not necessarily be members of the budget group. In order to be included in the budget group, there must be a tax filer or non-tax filer relationship.

APPLICANT- an individual who is seeking a PE Medicaid determination for herself through a PE Medicaid application submission.

BENEFICIARY- an individual who has been determined eligible and is currently receiving Medicaid.

TAX FILER- an individual who states they expect to file a tax return for the taxable year.

NON TAX FILER- an individual who state they do not expect to file a tax return, or does not expect to be claimed as a tax dependent by someone for the taxable year.

PARENT- natural/biological, adoptive or step.

CARETAKER RELATIVE- any nonparent adult that a child is living with and who assumes primary responsibility for the dependent child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes).

DEPENDENT CHILD- a child (natural/biological, adoptive, or step) who meets both of the following criteria:

- (1) Is under the age of 19;
- (2) Is deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment of at least one parent. A parent is considered to be unemployed if he or she is working less than 100 hours per month.

SIBLING- natural/biological, adoptive or step.

NON-APPLICANT- an individual who is not seeking an eligibility determination for himself or herself but is included in an applicant's or beneficiary's budget group.

BUDGET GROUP- the number of persons counted as members of an individual's household. This is based on either a tax filer household or a non tax filer household. The number in the budget group will determine what income limit is used.

TAX FILER HOUSEHOLD- the household consists of the taxpayer and all their tax dependents. All members of the tax filer's household are included in the budget group.

NON TAX FILER HOUSEHOLD- the household consists of individuals who live together, do not expect to file a Federal tax return, and do not expect to be claimed as a tax dependent for the taxable year. Must include in the budget group:

- The individual's spouse;
- The individual's natural/biological, adopted and step children under the age of 19; and
- The natural/biological, adoptive and step siblings, under the age of 19, of those children.

TAX DEPENDENT- an individual expected to be claimed as a dependent by someone else for a taxable year. Tax dependents can only be claimed once per taxable year.

INDIVIDUALS CLAIMED AS A TAX DEPENDENT- an individual who expects to be claimed as a tax dependent by a taxpayer for the taxable year. The tax dependents are included in the tax filer's household.

Three (3) exceptions for claimed tax dependents:

- Individual(s) being claimed as a tax dependent by someone other than a spouse; or is not the tax filer's natural/biological, adopted, or step child, are to be separated from the tax filer's budget group when ineligible for a Modified Adjusted Gross Income (MAGI) Medicaid together.
- Child(ren) living with both parents, expected to be claimed by only one parent as a tax dependent because the parents are not filing a joint tax return.
- Child(ren) claimed as a tax dependent by a non-custodial parent. A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or if there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

Note: If a taxpayer cannot reasonably establish that another individual is a tax dependent of a taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined. **This is not the same as refusing to acknowledge what their tax status is.**

MARRIED COUPLES- married couples living together; each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

On June 26, 2015, the Supreme Court, in *United States v. Obergefell ET AL. v. Hodges, Director, Ohio Department of Health, ET AL.* held: The Fourteenth Amendment requires a State to license a marriage between two people of the same sex and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out of state. As of June 26, 2015 Georgia recognizes same sex marriage for the Medicaid and PeachCare for Kids® programs. For Medicaid Modified Adjusted Gross Income (MAGI), Non-MAGI and PeachCare for Kids® programs the treatment of income and resources will be the same for same sex married couples and married couples of the opposite sex.

Pregnant Woman- each expected child is included in the budget group for PE Medicaid; pregnancy, and number of expected children, is based on the applicant's statement only. Only Pregnancy Medicaid and Presumptive Eligible (PE) Pregnancy Medicaid allow multiple expected births to be

included without medical verification of the number expected. All other Modified Adjusted Gross Income (MAGI) COAs need medical verification of multiple births; otherwise count a pregnant woman in the budget group as two (her and one unborn child).

502 Citizenship/Immigration Status

§435.406 Citizenship and alienage/SPA ATTACHMENT 2.6-A Page 2; S28-3; S89-1; S89-2; S89-3.

Policy

Citizenship/Immigrant status requirements are part of the PE program. Only U.S. citizens and qualified immigrants may qualify for PE Medicaid. Qualified immigrants that may qualify for Medicaid are:

1. Lawfully admitted immigrants who arrived in the United States **before August 22, 1996**, if they are:
 - a) asylees, refugees, or have been granted parole in the U.S. for at least one year or have had their deportation withheld.
 - b) lawful permanent residents.
 - c) honorably discharged U.S. veterans or active duty military personnel, their spouses, or their unmarried dependent children.
2. Lawfully admitted immigrants who arrived in the United States **on or after August 22, 1996**, if they are:
 - a) asylees, refugees, or have been paroled in the U.S. for at least one year, or if their deportation is being withheld.
 - b) lawful permanent residents who have been credited forty (40) quarters of employment (10 years) under the U.S. Social Security system and have not received any federal means tested benefits during that time. (The employment test may be met also by the individual's spouse or parent.)
 - c) honorably discharged U.S. military veterans or active duty military personnel, their spouses, or unmarried dependent children.

- d) individuals whose immigration status is in accordance with the Victims of Trafficking and Violence and Protection Act of 2000 (Public Law 106-386).
3. Lawfully admitted immigrants that entered the United States on or after August 22, 1996, and have been legal resident immigrant for five (5) years or more.

Revised
10/01/14

The term “refugee” is used when referring to refugees, asylees, Cuban Parolees/Haitian entrants, Amerasians, victims of trafficking and Special Immigrants from Afghanistan and Iraq.

Definition

Refugee - (a) any person outside his or her country of nationality or residence who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution on account of race, religion or political opinion or (b) any person within his or her country of nationality or residence who is persecuted or has a well-founded fear of persecution on account of race, religion or political opinion.

Procedures

QP/QH must have all applicants complete a Declaration of Citizenship/Immigrant Status **included in form 94A** (Appendix F), as part of the PE application process. As with income, the applicant’s statement of citizenship/immigrant status is acceptable. **Verification of citizenship/immigrant status is not required**; however, if the applicant does present proof of status at the PE interview, copies should be made and one retained in the PE file and one sent to the RSM/DFCS office with the PE packet.

If the applicant has proof of identity and/or citizenship obtain a copy for the **Health Coverage** application. Write “viewed and copied” on each copy, stickers may be used.

Acceptable citizenship/qualified immigrant and/or identity documents:
§435.407 Types of acceptable documentary evidence of citizenship

No Identity Required on these Citizenship Verifications:

- US Passport (not limited passports)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of Citizenship (N-560 or N-561)

Identity Required with these Citizenship Verifications:

- US Public Birth Record showing birth in one of the 50 states; District of Columbia; American Territories; or Guam
- US birth certificate or data match with a State Vital Statistic Agency Certification of Report of Birth (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the U.S.(FS-240) Certification of Birth Abroad (FS-545)
- United States Citizen Identification Card (I-197 or the prior version I-179)
- American Indian Card (I-872) with the classification “KIC” (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
- Collective Naturalization document/Northern Mariana Identification Card (I-873)
- Final Adoption Decree
- Evidence of civil service employment by the US government
- Official Military record
- Federal or State census record showing US citizenship indicating a US place of birth
- Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs
- Statement signed by the physician or midwife who was in attendance at the time of birth
- One of the following documents created at least 5 years before the application for Medicaid showing a US place of birth :
 - Extract of hospital record on hospital letterhead established at the time of person’s birth
 - Life, health or other insurance record
 - An amended US public birth record
 - Medical clinic, doctor or hospital record indicating a US place of birth
 - Institutional admission papers from nursing home, skilled nursing care facility or other institution

Acceptable Verification of Identity:

- State Driver’s license bearing the individual’s picture **or** Georgia Identification Card
- Certificate of Indian Blood; US American/Alaska Native tribal

- document; or Native American Tribal Document
- US Military Card or draft record; Military dependent's ID card with photograph; US Coast Guard Merchant Mariner Card
- Identification card issued by federal, state or local government agencies or entities with photo or identifying information
- School Identification card with a photograph
- US passport issued with Limitations
- Data matches or documents from law enforcement or corrections agencies such as police or sheriff's departments, parole office, DJJ and Youth Detention Centers

Applicants should not be denied PE, or the right to apply for the program, because they cannot provide proof of citizenship/immigrant status. The application should be denied when the applicant verbally states or form 94A indicates that the applicant is not a U.S. Citizen/Naturalized or is not a qualified immigrant. An affirmative entry on the form meets the criteria for citizenship/immigrant status. If one of these items is completed, the individual will be determined presumptively eligible provided that they are pregnant (per applicant's statement); the budget group's net taxable income is at or below 220% of the federal poverty level (FPL) income limit; and they are GA residents.

The approved and denied PE applications will be reviewed by the RSM/DFCS team to determine possible eligibility for Emergency Medical Assistance (EMA) for the applicant when the applicant completes the healthcare coverage application. EMA cannot be completed in PE.

A lawfully admitted immigrant who entered the U.S. for permanent lawful residence prior to August 22, 1996; or who entered the U.S. for permanent lawful residence after August 22, 1996, and who has lived in the U.S. for at least 5 years, **per the Department of Homeland Security**, meets the citizenship/qualified immigrant criteria for PE. These applications will be completed by the QP/QH, and should be approved if they meet the PE eligibility requirements.

If the applicant is verbally unable to confirm citizenship or that they are not a qualified immigrant then the QP/QH will deny the PE applicant and give the PE packet to the RSM/DFCS office. QP/QH will follow the procedures outlined in Chapter 703.

The applicant must be afforded the full opportunity to apply for PE Medicaid. This means all forms normally given during the course of the application process must be completed. The applicant cannot be given just the form 94A to complete and denied in the event she does not meet the citizenship/ immigrant status requirements.

Visitors, tourists, foreign students and diplomats are not eligible.

Copies of the form 94A, in English and Spanish, are contained in Appendix F. Ample copies should be kept on hand.

The day the applicant moves to GA, she is considered a Georgia resident. She does not have to have a fixed GA dwelling. A mailing address is required for applicants to receive Medicaid notifications, Medicaid cards, CMO information, and NET (non-emergency transportation), etc. If she is unable to provide a mailing address inform her the local DFCS office will be assigned as her address and she can obtain her mail at their office.

CHAPTER 600 FINANCIAL ELIGIBILITY REQUIREMENTS

601 Income

**§435.603 Application of modified adjusted gross income (MAGI)/SPA
Attachment 2.5-A Page 12; S28-2; S10-1; S10-2**

Income is money received by the budget unit from any source. Money received may be earned or unearned. **Earned income** is compensation received in exchange for services rendered. It may be in the form of wages, salaries, commissions, or self-employment. **Unearned income** is money received for reasons other than for services rendered. It may be in the form of pensions, contributions, gifts, child-support, strike benefits, or interest payments. **Only taxable income is used in the PE Pregnancy budget.**

Income may be received weekly, bi-weekly, semi-monthly, monthly, or some other payment schedule. Income received other than monthly must be converted to a monthly amount in order to perform the income comparison test for PE. The following table shows the conversion factor to use when determining monthly income. This table also appears in Appendix I – Income as part of the income limits table.

IF PAID	THEN MULTIPLY BY
HOURLY	Number of hours worked per week x (times) the hourly wage x 4.3333 weeks.
WEEKLY	Weekly gross income x 4.3333
BI-WEEKLY	Bi-weekly gross income x 2.1666
SEMI-MONTHLY	Semi-monthly gross income x 2
YEARLY	Divide the yearly gross income by 12.

602 Non Taxable Income

There are some income types that are not included in the determination of eligibility because they have been defined as non-taxable income and are excluded under federal statute. Some examples of excluded income are adoption assistance payments, TANF (formerly AFDC) benefits, earnings from the Census Bureau, disaster relief assistance, earned income tax credits, energy assistance payments, child support and VA. If the tax dependent/child has no other source of income and resides with a parent (biological, step, adopted), the Social Security RSDI income is excluded. RSDI of a tax dependent/child is countable only if the tax dependent/child has OTHER income that meets the IRS tax filing threshold for tax dependents or if the child does not reside with a parent and is not claimed as a tax dependent by his or her parent.

Revised
7/1/16

Income received from these sources is not included in any budget calculations to determine PE Pregnancy Medicaid. A list of exempt sources is included in Appendix I -Income.

603 Income Eligibility Limits

Income limits for PE Pregnancy Medicaid are based on 220% of the federal poverty level. The income limit used is determined by the number of people included in the budget unit.

The income limit for each budget unit size is given below and is included in Appendix I- Income.

PE Pregnant Women Medicaid 220% FPL Effective 4/1/16

FPL 2016 for Pregnant Woman Medicaid		
Budget Group	220%	Plus 5%
1	\$2,178	\$2,228
2	\$2,937	\$3,004
3	\$3,696	\$3,780
4	\$4,455	\$4,557
5	\$5,214	\$5,333
6	\$5,973	\$6,109
7	\$6,735	\$6,889
8	\$7,498	\$7,669
9	\$8,262	\$8,450
10	\$9,023	\$9,229

Add \$763 for each additional HH member

Revised
04/01/16

To be presumptively eligible for Medicaid benefits, the monthly budget group's net taxable income must not exceed the monthly income limit for the budget group's size. Net taxable income must be less than or equal to the income limit to establish eligibility. Net taxable income is taxable gross income minus allowable deductions.

The income limits are based on the federal poverty level (FPL) and change each time the poverty level changes. This change usually occurs in February, and the new limits are effective beginning on the first day of February. The limits are issued as soon as they are received from the U.S. Department of Health and Human Services.

Revised
04/01/15

The 200% FPL limit changed effective April 1, 2015 through January 31, 2016.

604 Determination of Taxable Income

Unless specifically exempt or otherwise excluded from consideration, all taxable income of the budget group must be counted in the PE Pregnancy Medicaid determination.

In addition to those income sources identified as exempt or excludable by statute, there are allowable deductions available to offset the taxable income.

The three allowable deductions are:

- Pre tax deductions
- Form 1040 deductions
- 5% FPL deduction

Taxable income of the applicant's child, who is 18 years old or younger, is disregarded in full if they are not required to file income taxes. Filing for a tax refund is not the same as filing a tax return.

The 18 year old is considered 18 for the entire year, including up to the last day of the month they turned 19 years old.

605 Taxable Earned Income

Earned income refers to the gross earnings of an individual received in the form of wages, tips, salaries or commissions, as payment for performing work duties, including self-employment.

When determining the taxable income to be included from self-employment activities, compared to the budget group's income limit, consider only the net taxable gross income. Net taxable gross income is the total profit from the business and deducting business expenses (those costs directly related to producing the goods or services that are allowable IRS deductions).

The applicant's statement regarding gross taxable income, receipts and costs of doing business, is accepted as establishing the amount of net taxable gross income to be included in the financial calculation. The applicant may state an amount equal to the net taxable gross income amount for a stated period.

Example:

Applicant is self-employed and states her monthly taxable gross income is \$10,000 per month, and herself employment monthly expense are \$8,000. QP/QH will take the \$10,000 and subtract the \$8,000 = \$2,000 as her net taxable gross income.

OR

Applicant can state her net taxable gross income is \$2,000.

After the net taxable gross income is established the allowable deductions are given.

When an individual receives food, shelter, clothing or some alternative payment other than cash for performing work activities, the value of these items is disregarded for the purposes of determining financial eligibility. These items are considered to be in-kind benefits that have no direct monetary value to the budget unit for purposes of meeting daily needs.

See Appendix I - Income for a chart of Taxable Earned Income.

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

As of April 1, 2003, approved applications can be processed manually or on-line. Procedures for both methods are specified in detail.

701 On-Line Procedures

The on-line process allows certain information contained on the completed PE application (form DMA 632) to be data entered into the GAMMIS system. Data entry of this information allows immediate update of the DCH/GAMMIS file and immediate generation of a Medicaid identification number.

The on-line process does not eliminate the requirement to interview the applicant and perform the eligibility determination. Further, the on-line process does not eliminate completion of appropriate forms. Only certain information contained on the completed PE application form DMA 632 is involved in the automated process.

Approvals

Only information from approved PE Pregnant applications can be entered into the GAMMIS system. The completed approved PE application (DMA 632) contains certain data elements that can be entered directly into the GAMMIS system.

When it is determined that the applicant is eligible and an approval is appropriate for PE Medicaid, adhere to the following procedures.

1. Data enter in the appropriate fields certain demographic information contained on the PE application. When processing over the Internet, the member's identification number will be issued by the system as part of the online process. If already known to the system use the same ID
2. If all data are entered correctly, the system will allow production of a temporary Medicaid certification form. Print out two copies of this document. Give the **beneficiary** a copy of the temporary Medicaid certification form. In addition to serving as a temporary Medicaid certification, this document serves as a notice to the **beneficiary** that she is approved for PE Medicaid. For the on-line process, if the temporary Medicaid certificate is not printed, use the Notice of Action, form DMA

634 Approval. Instruct the **beneficiary** to present this document to her providers as proof of PE Medicaid eligibility.

3. Retain a copy of the temporary Medicaid certificate/ DMA 634 Approval form in the record, along with a copy of the PE **application DMA 632**.
4. Within **five (5) business days or sooner, if possible**, refer the PE packet (PE application and supporting documents) to the local Right from the Start Medicaid (RSM) Project or the Division of Family and Children Services (DFCS) office.
 - QP/QH personnel should give the applicant the **temporary Medicaid certificate** and a copy included in the PE packet.
 - QP/QH personnel should give the local RSM/DFCS office the PE packet: a copy **of the DMA 632; a copy of the citizenship affidavit, form 94A, HIPAA form 5460**.
Additionally if the DMA 285 TPL form was signed, and the signed **Health Coverage** application (if completed) will also be included with the PE packet.

NOTE: The only part of the **Health Coverage** application that is required, after the completion of a PE application, is the applicant's name, contact information, and sign and date the application. All other information was obtained during the PE application process and any other information needed will be obtained during the post eligibility process by RSM/DFCS. The **Health Coverage** application is the point the applicant can request any prior month(s) coverage.

When the PE beneficiary has a TPL, the only part of the DMA 285 form that is required, after the completion of the PE application, is the top part of the form and signatures/date in both locations at the bottom of the form. This is the PE beneficiary's agreement to cooperate with TPL during post eligibility if a **Health Coverage** application is submitted.

- The local RSM/DFCS office will review the PE beneficiary's eligibility for ongoing and retroactive Medicaid if the Health Coverage application is included in the PE packet and prior month(s) coverage was requested.

Retroactive (prior months) Medicaid are protected by federal regulations, up to the three (3) prior months of the Medicaid application that can be potentially activated.

Retroactive Medicaid is not automatically given with every application; it must be requested by the applicant.

PE Medicaid does not allow for retroactive Medicaid to be determined. Only RSM/DFCS offices are able to complete retroactive Medicaid for PE Pregnant Women Medicaid applicants. The applicant must meet all the eligibility requirements for any month(s) requested and state they have at least one unpaid medical expense for each of the month(s) requested. Proof of the expense is not required.

ERRORS DISCOVERED PREVENTING ENTRY OF A PE INTO GAMMIS

When an issue occurs when trying to add the PE approval to GAMMIS, the following procedures are to be followed:

- 1. Fax the PE Application (form DMA 632) only to 1-866-483-1045**
- 2. Call HP at 1-800-766-4456**
- 3. Ask HP to transfer you to HP Member Enrollment for an Emergency Update**
- 4. Identify yourself as a Qualified Provider (QP) and give your agency's full name**
- 5. Inform HP Member Enrollment that you have just faxed the PE Application and give them the fax number it was faxed from**
- 6. The HP Member Enrollment will retrieve your fax (PE Application) and manually update the approval in GAMMIS while you are on the phone with them.**

If the beneficiary is already known to GAMMIS she will retain her Member ID number; if she is new to GAMMIS the HP Member Enrollment will give you her Member ID number.

After you have been given her Member ID number, give the beneficiary form DMA 634 Approval letter; include a copy in the PE packet.

ERRORS DISCOVERED AFTER PE HAS BEEN SUBMITTED

Providers are encouraged to exercise care when executing the online process. Errors on a Presumptive Eligibility record will cause denials or delays in the payment of claims, and prevent a beneficiary from receiving services.

After GAMMIS accepts the information and issues a member identification number, errors on a record, such as an incorrect date of birth, wrong social security number, or improper spelling of a name, duplicate ID number issued, etc. cannot be corrected through the system. These must be corrected by contacting **HP**.

To have these corrections completed, QPs/QHs will fax HP Member Enrollment at 1-866-483-1045 using the PE Coversheet and attached the PE application; do not include any other pages in the fax.

HP has three (3) business days after receipt of the PE Coversheet and PE application form to update the changes in GAMMIS.

The PE Coversheet can be found in Appendix F.

See Appendix M for MEMO dated 3/9/12 for instructions.

702 Manual Approvals

Only **approved** PE applications are to be sent to GAMMIS for data entry. The manual procedure is to be followed when the provider **does not** have access to the on-line Internet PE application in GAMMIS.

When it is determined that the applicant is eligible and an approval is appropriate for PE Medicaid, adhere to the following procedures.

1. Upon completion of the PE application, call HP to have it manually updated. Give the PE beneficiary form DMA 634 Approval, Notice of Action. The beneficiary should present these to her medical care and pharmacy providers.
2. Within **five (5) business days or sooner, if possible**, refer the PE packet (PE application and supporting documents) to the local Right from the Start Medicaid (RSM) Project or the Division of Family and

Children Services (DFCS) office.

- QP/QH personnel should give the local RSM/DFCS office the PE packet: a copy of the **DMA 632**; a copy of the **citizenship affidavit, form 94A, HIPAA form 5460**.
Additionally, if the DMA 285 TPL form was signed, and the singled **Health Coverage** application (if completed) will also be included with the PE packet.

NOTE: The only part of the **Health Coverage** application that is required, after the completion of a PE application, is the applicant's name, contact information, and sign and date the application. All other information was obtained during the PE application process and any other information needed will be obtained during the post eligibility process by RSM/DFCS. The **Health Coverage** application is the point the applicant can request any prior month(s) coverage.

When the PE beneficiary has a TPL, the only part of the DMA 285 form this is required, after the completion of the PE application, is the top part of the form and signatures/date in both locations at the bottom of the form. This is the PE beneficiary's agreement to cooperate with TPL during post eligibility if a **Health Coverage** application is submitted.

The local RSM/DFCS office will review the PE beneficiary's eligibility for ongoing and retroactive Medicaid if the **Health Coverage** application is included in the PE packet and prior month(s) coverage was requested.

703 Denied Applications

When the application is denied, it **cannot** be data entered. Since denied applications cannot be entered into the GAMMIS system, they are to be processed in the following manner.

Reasons for denial are: 1) The applicant is not a U.S. citizen or qualified immigrant. 2) The applicant is not pregnant per her statement. 3) The applicant's net taxable income is above 220% of the federal poverty level limit. 4) The applicant is not a GA resident. 5) Unable to determine, applicant refuses to verbally give tax status information.

After completion of an application form DMA 632 and it is determined that the applicant is **not eligible** and the application is to be **denied** for PE, adhere to the following instructions:

1. Complete and give the applicant a copy of the **Notice of Action, DMA 634 Denial**. In the case of a denial, this is the **only** form the applicant receives for PE Medicaid.
2. Within **five (5) business days or sooner, if possible**, give the PE packet to the RSM/DFCS office.

Note: Since denied applications cannot be data entered, all QP/QH offices, including those with Internet access, must follow these procedures for denials.

If a **Health Coverage** application was signed and submitted as part of the PE packet, and the applicant is found ineligible for any Medicaid, the computer system will send the application to the Federally Facilitated Marketplace (FFM). The applicant will be notified directly by the FFM.

The applicant may find additional FFM information, or apply directly for Healthcare coverage at www.healthcare.gov, or they may call the FFM any time at 1-800-318-2596, TTY 1-855-889-4325.

APPENDIX A - QUESTIONS & ANSWERS

1. What forms are needed for a PE application?

- Application form DMA 632
- Declaration of Citizenship form 94A
- HIPAA form 5460

2. Do I need a separate Declaration of Citizenship form 216 if I am using the single streamlined Medicaid application form?

No. The signed single streamlined Medicaid application contains the declaration language needed.

3. Can I just have them complete form 216 and if they are not U.S. Citizens or Qualified Immigrants and just not let them complete an application?

No. Anyone whom requests PE Medicaid must be given an application. Not everyone will be approved for PE, but they must be given an application.

4. What reasons can PE Medicaid be denied for?

- Not being pregnant
- Not being a U.S. Citizen or Qualified Immigrant
- Not being at or below the 220% FPL net taxable income limit
- Not being a Georgia resident
- Unable to determine, applicant refuses to give verbal tax status information

5. What must I inform the applicant of once approved for PE Medicaid?

- Inform the applicant they have been approved.
- Explain what PE Medicaid is.
- Explain what PE Medicaid covers and does not cover.
- Explain what a temporary Medicaid certificate is and how they should use it.
- Explain WIC and assist them to apply.

- Explain the **Health Coverage** application will be given to the RSM/DFCS office (if completed) to make the Medicaid determination, or they can file an application directly with DFCS at www.compass.ga.gov
- Explain what Medicaid will cover.
- Give the applicant the Quick Guide on Medicaid For Pregnant Women, and review the information.
- Inform the member of Planning for Healthy Babies (P4HB).
- Give them the Understanding Medicaid Booklet

6. What must I inform the applicant of once denied for PE Medicaid?

- Inform the applicant they have been denied, and why.
- Give them form DMA 634 Denial Notice of Action and review it with them.
- Explain the **Health Coverage** application will be given to the RSM/DFCS office (if completed) to make the Medicaid determination, or they can file an application directly with DFCS at www.compass.ga.gov
- Inform the applicant about Planning for Healthy Babies (P4HB).

7. If the application is approved can I just have the information manually updated by **GAMMIS**?

No. If the QP/QH has access to the on-line web portal internet they must enter the application information on-line. This is also how the temporary Medicaid certificate will be generated. If the QP/QH does not have access to the on-line internet application then the approved applications are to be sent to **HP's Member Contact Center** for manual entry; refer to section 702 for more detail.

8. What happens if the applicant is already active on Medicaid?

QP/QH should screen applications to confirm the applicant is not active on Medicaid. If the beneficiary is active on Medicaid, other than P4HB aid categories 180-181, or Q Track all 600 aid categories, do not complete a PE application on line as PE is only temporary Medicaid.

Instead give the beneficiary information of her pregnancy and inform her to give this to their DFCS case manager or they can call the DFCS Call Center at 1-877-423-4746 to report their pregnancy.

Those beneficiaries that are active for P4HB, aid categories 180-181, accept and complete the PE application and follow normal PE application procedures. Beneficiaries that are active P4HB 182 or 183 have full Medicaid already, give them information of their pregnancy and have them to give this to DFCS or call the DFCS Call Center.

Beneficiaries active on SSI Medicaid, follow procedures to have the pregnancy information updated on GAMMIS using the SSI Pregnant Women Update form.

Beneficiaries active on WHM, inform MORROW of the pregnancy information.

Beneficiaries on PeachCare for Kids® that remain active on PeachCare for Kids® are to report their pregnancy information to PeachCare for Kids®.

See Appendix C for a list of different types of Medicaid.

See Appendix M, memorandum on Planning for Healthy Babies (P4HB) Family Planning Waiver, for more information.

9. What happens if I have problems getting the applicant added on the web portal?

QP/QH should follow the procedures outlined in Chapter 700.

10. How do I screen an applicant on the web portal?

See step by step process in Appendix G.

11. The applicant receives Food Stamps, does this count as income in her PE budget?

No. Food Stamps, Temporary Assistance to Needy Families (TANF) and Supplemental Security Income (SSI) are not counted as income in the budget.

See Chapter 600 and Appendix I – Income for Taxable Income information.

12. What does the “Right to Apply” mean?

The right to apply has a twofold meaning. The first being that anyone that walks into your office and request to apply for PE Medicaid, they must be given an application at that moment.

Second, anyone that would like to submit an application during normal operating office hours must be allowed to do so.

The right to apply does not mean the application must be completed the same day as they could walk in your office on a Friday at 4:58 p.m. The application should be processed timely the following business day. Nor does the right to apply mean everyone is eligible for PE Medicaid.

The right to apply also does not mean that a QP/QH is allowed to approve back to back PE applications.

The Affordable Care Act (ACA) only allows one approved PE Pregnant Women Medicaid application per the same pregnancy.

13. How do I order forms?

Form DMA 632 can only be printed from the Web.

Form **94A** and 5460 should be obtained through RSM or DFCS. Form 634, Approval and Denial, can be printed from **the Web**.

TPL DMA 285 can only be printed from the Web.

The **Health Coverage** application can be obtained from RSM or DFCS.

14. If someone has a question regarding P4HB who should they talk to?

Beneficiaries should speak to their MCHB regarding P4HB.

Applicants should contact MAXIMUS for questions regarding P4HB:
1-877-744-2101

Fax 1-888-744-2102

www.planning4healthybabies.org

Providers should contact their MCHB for all P4HB questions including services, claims, etc.

Qualified Providers, such as the Department of Public Health, or **Qualified Hospitals** should email pecorrections@dch.ga.gov , regarding any P4HB regulations. Anything regarding claims/codes etc. will need to be handled by the MCHB.

15. If I am adding the PE on to the Web, do I need a form 632?

Yes. The form DMA 632 is the PE Pregnancy application. An application is needed to apply for PE Medicaid.

Adding the information onto the Web is an instant update which allows all providers to see the beneficiary's eligibility once it is entered on the Web. This allows the beneficiary to obtain immediate medical care which is the purpose of completing PE Medicaid.

All providers are required to verify Medicaid eligibility via the Web or by calling HP mainly through the IVR system or by speaking with the HP Provider Contact Center. Beneficiaries having proof of their eligibility is no longer used to validate their eligibility per House Bill 1234.

16. Who is a Green Card Holder (Permanent Resident)?

A Green Card holder (permanent resident) is someone who has been granted authorization to live and work in the United States on a permanent basis. As proof of that status, a person is granted a permanent resident card, commonly called a "Green Card."

An immigrant can become a permanent resident several different ways. Most immigrants are sponsored by a family member or employer in the United States. Other may become permanent residents through refugee or asylee status or other humanitarian programs. In some cases, immigrants may be eligible to file for themselves.

What is an I-94 Form (Arrival-Departure Record, Form I-94 Card)?

As a nonimmigrant, a U.S. Customs and Border Protection (CBP) I-94 Form (Arrival-Departure Record, Form I-94 Card) or Form I-95 (Crewman's Landing Permit) shows the date you arrived in the United States and the "Admitted Until" date, the date when your authorized period of stay in the US expires.

Student Visa Overview

There are three major types of student visas that an international student can come on to the United States to study. Student visas are issued for the period it takes the visitor to complete his/her course of study, program or work assignment.

1. F1 Visa: Academic Studies

For people who want to study or conduct research at an accredited U.S. College or University. In order to be qualified for getting an F1, you must be accepted by an recognized university as a full time student. You must also prove the sufficient proof of financial support during this stay in United States. Except for the training required by the course a F-1 holder cannot work in the United States.

2. J Visa: Academic Studies as an Exchange Visitor

For people who will be participating in an exchange visitor program in the U.S. The J Visa is the primary visa for educational and cultural exchange programs.

3. M Visa: Non-Academic or Vocational Studies

For people who want to study or train at non-academic institutions in the U.S. such as vocational schools.

Business Visa

For those visiting USA temporarily on a business visa, also known as **B1** visa.

Work Visa

The **H1B** visa is an employment-based, non-immigrant visa category for temporary workers. For such a visa, an employer must offer a job and apply for your H1B visa petition with the US Immigration Department. This approved petition is a work permit which allows you to obtain a visa stamp and work in the U.S. for that employer.

A spouse and children (age under 21) of H1 visa holders can qualify for **H4** visa. H4 visa holders are not permitted to work in U.S. They will accompany a legally employed person in the United States on a dependent visa.

Visitor VISA

USA Visitor Visa is a tourist visa to US. It is also known as **B2** Visa. Visitor visa is a non-immigrant visa issued to people entering US temporarily for pleasure, tourism, or medical treatment. Any foreign citizen including parents who wants to visit USA for tourism, visiting children, family, friends, relatives, attending special events, family functions, ceremonies, or for medical treatment may qualify and can apply for Visitor Visa.

APPENDIX C- CLASS OF ASSISTANCE

Aid Category

Medicaid

104 –Parent/Caretaker Adult	Medicaid benefits for eligible adults that have a qualifying child.
105 – Parent/Caretaker Child	Medicaid benefits for eligible children up to age 19 and the adult(s) who are responsible for those children.
118 - 1st yr. TMA Adult 119 - 1st yr. TMA Child 120 -2nd yr. TMA Adult 121 - 2nd yr. TMA Child	Medicaid coverage for up to 12 months to beneficiaries that become ineligible for Parent/Caretaker with Child(ren) Medicaid because of changes related to earned income.
122 - 4MEX Adult 123 - 4MEX Child	Four Months Extended Medicaid because of Spousal Support. Provides 4 months of Medicaid coverage for a Parent/Caretaker with Child(ren) Medicaid member who has become ineligible because of new or increase spousal support.
131 - Child Welfare Foster Care	IV-B Foster Care Medicaid provides coverage to children in placement for whom DFCS has partial or total custody.
132 - State Funded Adoption Assistance	Continuation of IV-E Adoption Assistance Medicaid once the child turns 18 years old.
133 - IV-E Foster Care	IV-E Foster Care Medicaid provides coverage to children in placement for whom DFCS has partial or total custody and who are eligible for IV-E Foster Care.
134 - IV-E Adoption Assistance	Adoptive children who are determined eligible for IV-E Adoption Assistance (AA) are eligible to receive IV-E Adoption Assistance Medicaid if citizenship/immigration status criteria are met.
135 - Newborn Child	Newborn (NB) Medicaid provides Medicaid coverage to a child born to a woman who was eligible for and receiving Medicaid on the day the child was born. A child is eligible for Newborn Medicaid for up to 13 months beginning with the month of birth and continuing through the month in which the child reaches age 1.
136 - PCK/MA	Former Peachcare for Kids® members eligible for Medicaid due to FPL changes. Available to children from birth through the last day of the month of the child's 19th birthday.
137 - PCK/MA Foster Care	Former Peachcare for Kids® members whose income exceeds the Foster care limits. Available to children from birth through the last day of the month of the child's 19th birthday.
138 - PCK/MA DJJ	Former Peachcare for Kids® members with a DJJ placement Available to children from birth through the last day of the month of the child's 19th birthday.
139 - PCK/MA DJJ/RDYC	Former Peachcare for Kids® members with a DJJ/RDYC placement. Available to children from birth through the last day of the month of the child's 19th birthday.

Revised
10/01/15

140 - PCK/MA IVB Children	Former Peachcare for Kids® members with IVB Medicaid placement. Available to children from birth through the last day of the month of the child's 19th birthday.
147 - Family Medically Needy Spend Down Child	Family Medicaid Medically Needy (FM-MN) provides Medicaid coverage for children under 19 years of age whose BG income exceeds limits for all Family Medicaid COAs and PeachCare for Kids®.
148 - Pregnant Woman Medically Needy Spend Down	Family Medicaid Medically Needy (FM-MN) provides Medicaid coverage for pregnant women whose BG income exceeds limits for all Family Medicaid COAs and PeachCare for Kids®.
170 - 194 - 197 Pregnant Woman	Medicaid to eligible pregnant women who meet eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).
171 - 172 - 195 - 196 Children Under 19 Years of Age	Medicaid to eligible children through the month in which the child turns 19 years of age who meet eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).
177 - Family Planning Waiver 180 - P4HB IPC 181 - P4HB Family Planning 182 - P4HB Family RM 183 - P4HB ABD RM	The original Family Planning Waiver no longer active Planning for Healthy Babies IPC Planning for Healthy Babies Family Planning Waiver Resource Mother for Family Medicaid beneficiaries Resource Mother for ABD beneficiaries
210 - 211 - 212 Nursing Home	An aged, blind or disabled member that resides in a nursing home.
215 - 216 - 217 30 Day Hospital	An aged, blind or disabled member that has been hospitalized for 30 or more consecutive days.
218 - 219 - 220	ABD Protected Medicaid 1972 COLA
221 - 222 - 223	ABD Disabled Widow(er) 1984 COLA
224 -225 - 226 Pickle	Pickle (PL 94-566) is a class of assistance (COA) that provides for an individual or couple who correctly received RSDI and SSI or a Mandatory State Supplement (MSS) concurrently and became ineligible for SSI or MSS because of the RSDI COLAs.
227 - 228 - 229 Disabled Adult Child	Disabled Adult Child (PL 99-643) is a class of assistance (COA) that provides Medicaid for an individual 18 or older who had his/her SSI terminated on or after 7/1/87 because of an entitlement or an increase in RSDI income received as a disabled adult child.
230 - 231 - 232 Disabled Widow(er) Age 50-59 Age 60-64	The Disabled Widow(er) class of assistance (COA) provides Medicaid for an individual whose SSI was terminated because of his/her entitlement to an RSDI disabled widow(er) benefit.
236 - 237- 238	ABD three (3) months prior Medicaid

245 Women's Health Medicaid (WHM)	Ongoing WHM for women with breast and/or cervical cancer.
246 GMWD	Georgia Medicaid for Workers with Disabilities (GMWD), offers people with disabilities, who are working, the opportunity to pay a small premium for health care coverage through Medicaid. GMWD provides Medicaid coverage to workers with disabilities who are employed but are no longer eligible for SSI due to increased earnings. The individual must have at one time been a recipient of SSI or SSA disability or been determined disabled.
247 - Disabled Child 1996	Former SSI-Disabled Child, for children who were terminated from SSI due to a new definition of disability according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
250 Deeming Waiver	ABD Katie Beckett - Medicaid for children under 18 years of age that qualify for institutional care but stay at home.
251 ICWP	Independent Care Waiver Program provides in home care to individuals who are Severely Physically Disabled or who have Traumatic Brain Injuries. The individuals cannot physically care for themselves and require assistance for daily functioning.
256 NOW	New Options Waiver (NOW) offer services and support that enable eligible individuals to remain living in their own or family home and participate in community life
257 COMP	Comprehensive Supports Waiver Program (COMP) provides residential care for individuals with intellectual and related developmental disabilities (I/DD) who require comprehensive and intensive services; need out-of home residential support and supervision or intensive levels of in-home services to remain in the community.
258 CBAY	The Community-Based Alternatives for Youth (CBAY) Waiver Program allows Medicaid eligible youth who would otherwise have been placed in Psychiatric Residential Treatment Facilities (PRTF) or were transitioned from PRTFs to receive community-based services thus preventing re-institutionalization.
259 CCSP	Community Care Services Program is designed to provide in home and community-based services to individuals. These individuals meet the criteria for nursing home placement but choose to remain in a residential home situation.
280 - 281 - 282	ABD Hospice
289 - 290 - 291	ABD Institutional Hospice
All 300 codes	SSI Medicaid
All 400 codes	SSI Ex-Parte Medicaid
All 500 codes	Refugee Medicaid

660 QMB	Qualified Medicare Beneficiaries (QMB) is a Q Track class of assistance (COA) that provides a Medicare supplement to individuals who meet financial criteria based on the Federal Poverty Level (FPL).
661 SLMB	Specified Low-Income Medicare Beneficiaries (SLMB) is a Q Track class of assistance (COA) that pays the monthly premium for Medicare Supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal poverty level (FPL).
662 QI1	Qualifying Individuals – 1 (QI-1) is a Q Track class of assistance (COA) that pays the monthly premium for Medicare supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal Poverty Level (FPL). Eligibility criteria are identical to SLMB except that the coverage is time limited depending on available State funds and the income limit is higher than SLMB Limit
790 - 791 - 792 - 793 PeachCare for Kids®	PeachCare for Kids® (PCK) provides medical insurance for children who are financially ineligible for Medicaid. Available to children from birth through the last day of the month of the child's 19th birthday.
800 Presumptive Women's Health Medicaid	Presumptive WHM for women with breast and/or cervical cancer determined by Qualified Providers/Qualified Hospitals only.
835 Presumptive Newborn	Newborn Medicaid given to deemed newborns by 378 specialty code providers only.
864 Presumptive Pregnant Woman	Presumptive Pregnant Medicaid for pregnant woman determined by Qualified providers/Qualified hospitals only. (Effective 02/26/15)
865 Presumptive Pregnant Woman	Presumptive Pregnant Medicaid for pregnant woman determined by Qualified Providers/Qualified Hospitals only. Discontinued 02/26/15)
801 Presumptive Parent/Caretaker Adult Medicaid	Presumptive Parent/Caretaker Medicaid benefits for eligible adults that have a qualifying child.
802 Presumptive Parent/Caretaker Child Medicaid	Presumptive Parent/Caretaker Medicaid benefits for eligible children up to age 19 and the adult(s) who are responsible for those children.
806 Presumptive Child(ren) under 19 Years of Age	Presumptive Medicaid to eligible children through the month in which the child turns 19 years of age who meet eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).
852 Presumptive Former FosterCare	Continuation of FosterCare Medicaid for former foster care beneficiaries that received FosterCare Medicaid and are no longer eligible for FosterCare Medicaid and are under 26 years of age.

Revised
04/01/15

Appendix E - Examples

Presumptive Eligibility Period

1. Ms. Smith applies in your office on 2/11/XX and is approved. Her PE eligibility period begins on 02/11/XX and will end on the last day of the following month, 3/31/XX.
2. Ms. Washington applies in your office on 5/1/XX; her PE period would be 5/1/XX through 6/30/XX.
3. Ms. Hernandez applies 12/31/XX in your office. Her PE period will start 12/31/XX and end 1/31/XX.

The PE period begins on the approved application date, and ends when ARSM determines eligibility or ineligibility for Medicaid, but no later than at the end of the following month of the PE approval. *The web portal has been updated and coverage no longer reverts to the beginning of the month for Presumptive Eligibility.

Revised
04/01/15

Budget Group Composition

1. Sally Jones, age eighteen, has two children under the age of three who live with her in her mother's home. Two of Sally's brothers live in the home also, they are 17 and 15 years of age. The father of her children is not in the home. Sally's mom expects to claim everyone in the household on her tax return. Sally is applying for Pregnancy Medicaid for herself. Who is included in the budget group?

Sally, her fetus and her two children, her two brothers, and her mother are all included in the budget group.

The budget group would be same if this was a non-tax filer household.

The budget group would only be Sally, her two children and her fetus if she expected to file her own tax return or had she been nineteen and this was a non-tax filer household.

2. Marcy Brown lives with her husband, her daughter, two mutual children, and his son. Marcy is employed and earns \$2100.00, per month. Her husband is employed as a machinist and earns \$3728.00, per month. Marcy receives \$675.00, per month, child- support for her daughter. Mr. Brown is expected to file a tax return and claim his wife, his step daughter, his son, and the two mutual children. Marcy is applying for Pregnancy Medicaid for herself. Who is included in the budget group?

Mr. and Mrs. Brown, her fetus and their two children and Ms. Brown's daughter and Mr. Brown's son will all be included in the budget group.

3. Jane Smith lives with her boyfriend, and her eighteen year old son. She is applying for Pregnancy Medicaid. Jane doesn't expect to file a tax return. Who is included in the budget group?

Jane, her fetus and son are included in the budget group.

If Jane's boyfriend was the father of her son, the budget group would include Jane, her fetus and son and her boyfriend because he is the other parent.

If Jane and the other parent both expected to file a tax return, only one of them could claim the son as a tax dependent. Count all of them in the budget group and include the fetus.

If they were married and expected to not file a joint tax return, they would all be counted in the budget group and include the fetus.

4. Lucy White lives with her disabled husband who receives SSI benefits and a small pension. Their oldest son also receives SSI for a disability. The two younger children are healthy and attend school regularly. Lucy is employed as a part-time Avon sales woman but is unable to work very much because of her son's illness. Lucy is applying for Pregnancy Medicaid for herself. Lucy doesn't expect to file a tax return. Who is included in the budget group?

Lucy, her fetus, spouse and their three children will all be included in the budget group.

SSI beneficiaries are included in the budget group but their SSI income is not.

Unearned income is calculated with the same conversion factor as earned income.

Conversion Factor

Paid/Receives \$156.00 gross weekly = $156 \times 4.3333 = \$675.99$
 \$156.00 gross bi-weekly = $156 \times 2.1666 = \$337.98$
 \$156.00 gross twice a month = $156 \times 2 = \$312.00$

Paid/Receives \$50-\$65 = $50 + 65 = 115/2 = \$57.50$
 Gross weekly = $\$57.50 \times 4.3333 = \249.16
 Gross bi-weekly = $\$57.50 \times 2.1666 = \124.57
 Gross twice a month = $\$57.50 \times 2 = \115.00

Pre-tax Deductions:

Pre-tax deductions are removed from gross income before taxes are applied. The most common types are Health Insurance, dental insurance, vision insurance, etc. Not every income amount deducted from gross income is considered a pre-tax. Line 1 on the W2 form is what is entered on Line 7 of the tax return form 1040.

22222		a Employee's social security number		OMB No. 1545-0008				
b Employer identification number (EIN)			1 Wages, tips, other compensation		2 Federal income tax withheld			
c Employer's name, address, and ZIP code			3 Social security wages		4 Social security tax withheld			
			5 Medicare wages and tips		6 Medicare tax withheld			
			7 Social security tips		8 Allocated tips			
d Control number			9		10 Dependent care benefits			
e Employee's first name and initial		Last name		Suff.		11 Nonqualified plans		12a
						13 Statutory employee <input type="checkbox"/> Retirement plan <input type="checkbox"/> Third-party sick pay <input type="checkbox"/>		12b
						14 Other		12c
f Employee's address and ZIP code								12d
15 State	Employer's state ID number		16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name	
Form W-2 Wage and Tax Statement				2013		Department of the Treasury—Internal Revenue Service		

1040 Deductions:
Are located on the IRS Tax Return form 1040:

Adjusted Gross Income	23	Educator expenses	23			
	24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24			
	25	Health savings account deduction. Attach Form 8889	25			
	26	Moving expenses. Attach Form 3903	26			
	27	Deductible part of self-employment tax. Attach Schedule SE	27			
	28	Self-employed SEP, SIMPLE, and qualified plans	28			
	29	Self-employed health insurance deduction	29			
	30	Penalty on early withdrawal of savings	30			
	31a	Alimony paid b Recipient's SSN ▶	31a			
	32	IRA deduction	32			
	33	Student loan interest deduction	33			
	34	Tuition and fees. Attach Form 8917	34			
	35	Domestic production activities deduction. Attach Form 8903	35			
	36	Add lines 23 through 35	36			
37	Subtract line 36 from line 22. This is your adjusted gross income ▶	37				

Income

Michele Brown is expecting twins and she lives with her husband, her daughter (15), and three mutual children (8, 10, and 11). Michele is employed and earns \$2310.00, per month. She pays \$184 monthly for vision insurance (pre-tax). Her husband is employed as a machinist and earns \$2693.00, per month. He pays \$300 monthly for MARTA (pre-tax), \$298 monthly for dental insurance and \$800 monthly alimony to his ex-wife. Michele receives \$1022.00, per month, child- support for her daughter. Determine financial eligibility.

Revised
04/01/15

\$ 2310.00 Mrs. Brown's earned income
\$ -184.00 Vision Insurance/Pre-tax
 \$ 2126.00 Mrs. Brown's net taxable income

\$ 2693.00 Mr. Brown's earned income
\$ -300.00 MARTA/Pre-tax
 \$ 2393.00
\$ -\$298.00 Dental Insurance/Pre-tax
 \$ 2095.00
\$ -800.00 Alimony/1040 Deduction
 \$ 1295.00 Mr. Brown's net taxable income

\$ 2126.00 Mrs. Brown's net taxable income
\$ 1295.00 Mr. Brown's net taxable income
 \$ 3421.00
\$ -171.00 5% FPL

\$ 3250.00 = total net taxable income for the BG of 8

Pregnancy Medicaid BG of 8 income Limit = \$7,498; PE eligible

Mrs. Jones is six weeks pregnant and lives with her husband, their 15 year-old son, and 3 year-old daughter. Mrs. Jones earns \$421.00, per month, as a cashier. Mr. Jones works as a security guard and earns \$960.00, per month. Their son is a full-time student and earns \$75.00, per month, by delivering newspapers one hour each morning before school. Mrs. Jones pays \$250.00, per month, for their daughter to attend the Jack and Jill Nursery School. The family will file a tax return and claim everyone in the household. There are no pre-tax or 1040 deductions to the best of Mrs. Jones' knowledge. Determine financial eligibility.

Revised
04/01/15

\$ 421.00 Mrs. Jones' taxable earned income
 \$ 960.00 Mr. Jones' taxable earned income
 \$ 1381.00 Total taxable net income
 \$ -119.00 5% FPL
 \$ 1262.00 = total net taxable income for the BG of 5

Pregnancy Medicaid BG of 5 income Limit = \$5,214; PE eligible

EFFECTIVE FOR SERVICES BEGINNING February 01 201X HP PROVIDER CONTACT CENTER P.O. BOX 105200 TUCKER, GA 30085-5200 PHONE: 1-800-766-4456 FAX: 1-866-483-1044 222333444567 MEDICAID IDENTIFICATION NUMBER February and March 201X VALID FOR LISTED MONTH ONLY

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANCY MEDICAID

APPLICANT'S NAME: Charlie Jones MAIDEN NAME: Washington TYPES OF TAXABLE INCOME: W - WAGES/SALARIES P - PENSION S - SELF EMPLOYMENT U - UNEMPLOYMENT OE - OTHER EARNINGS OU - OTHER UNEARNED HEALTH INSURANCE: YES NO

APPLICANT'S ADDRESS: 235 West Peach Street TELEPHONE NUMBER: 404-555-1245 APARTMENT/LOT NUMBER: #4 SOCIAL SECURITY NUMBER: 098-76-5432 CITY: Atlanta STATE: GA ZIP CODE: 30303 COUNTY OF RESIDENCE: Fulton

ID	TAX FILER HOUSEHOLD <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NON TAX FILER HOUSEHOLD <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	FIRST NAME	MI	LAST NAME	SUFFIX	DATE OF BIRTH MM/DD/YYYY	ORDER	SEX	RELATION TO APPLICANT	MONTHLY GROSS TAXABLE INCOME			MONTHLY DEDUCTIONS		MONTHLY NET TAXABLE INCOME	
										TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	PRE-TAX DEDUCTION		1040 DEDUCTION
01		Charlie A.		Jones		7/22/1975	F	W	SELF	W	421.00	MO	421.00	0	0	421.00
02	UNBORN CHILD <input type="checkbox"/> NA <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	APPLICANT'S STATEMENT														
03		Mark P.		Jones		3/14/1972	M	B	Husband	W	960.00	MO	960.00	0	0	960.00
04		Mark P.		Jones Jr.		1/3/199X	M	B	Son	W	75.00	MO	75.00	0	0	0
05		Jamie B.		Jones		9/29/201X	F	B	Child		0		0	0	0	0
06																

SWORN STATEMENT OF APPLICANT:
 I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE RIGHT FROM THE START MEDICAID (RSM) PROJECT OR THE COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) OFFICE WILL DETERMINE MY CONTINUING ELIGIBILITY WHEN I SUBMIT A SINGLE STREAMLINED MEDICAID APPLICATION.
 I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IMMIGRANT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY HOUSEHOLD, PREGNANCY, RESIDENCY, TAX STATUS AND INCOME.
 I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).
 I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH THE RSM OR DFCS OFFICE MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY, OR NO LATER THAN THE LAST DAY OF THE FOLLOWING MONTH.
 I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS THROUGH WWW.COMPASS.GA.GOV OR CALL 1-877-423-4746 (TDD/TTY 1-800-255-0135); FAX 1-888-740-9335.

TOTAL GROSS TAXABLE INCOME - 1381.00 SUBTOTAL NET INCOME - 1381.00
 NUMBER IN BUDGET GROUP - 5 5% FPL DEDUCTION - 117.00
 POVERTY INCOME LEVEL - 5118.00 TOTAL NET INCOME - 1264.00
 APPLICANT IS ELIGIBLE OR INELIGIBLE FOR PRESUMPTIVE ELIGIBILITY MEDICAID
 THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY 6 WEEKS PREGNANT WITH 1 FETUS(ES). HER EXPECTED DELIVERY DATE IS 5/14/01
 I HAVE OBTAINED A SIGNED HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FORWARDED IT TO RSM OR THE COUNTY DFCS OFFICE. YES (Included in PE Packet) NO

DATE OF COMPLETION 3/3/201X COMPLETED BY (PLEASE PRINT) Mami Wilson TITLE Doctor
 (404) 463-0512 SIGNATURE OF QUALIFIED PROVIDER PERSONNEL Mami Wilson
 QUALIFIED PROVIDER NAME AND ADDRESS Fulton County Department of Public Health QUALIFIED PROVIDER ID 009251458P
2 Peachtree Street, NW, #39, Atlanta, GA 30303

DATE OF APPLICATION 2/28/1X APPLICANT'S SIGNATURE Charlie Jones
 *By providing false information, you will assist us in administering our programs in a non-discriminatory manner. You are not required to give us this information and it will not affect your eligibility or benefit level.
 IDMA 402 (02/01/09)

REIMBURSEMENT FOR MEDICAID SERVICES THROUGH THE PRESUMPTIVE ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL SERVICES OR DELIVERY

Susie Thompson (39) is pregnant and lives with her children, Katie (6) and Pamela (15). Mr. Thompson is employed and earns \$350/weekly. She pays \$50/month for dental insurance and \$20/month for vision insurance. The children only receive \$450/month for RSDI. Ms. Thompson does file taxes and claims all three kids as tax dependents. Determine financial eligibility.

Revised
7/1/16

\$350 x 4.3333 =	\$1516.65	Ms. Thompson's earned income
	<u>\$ -50.00</u>	Dental Insurance/Pre-tax
	\$1466.65	
	<u>\$ -20.00</u>	Vision Insurance/Pre-tax
	\$1446.65	Ms. Thompson's net taxable income
	<u>\$-102.00</u>	5% FPL (BG of 5)
	\$1344.65	Total net taxable income

*RSDI for the children is **excluded** because they have no other income and live with a parent.

Pregnancy Medicaid BG of 4 income Limit = \$4455; PE eligible

Appendix F: FORMS Table of Contents

Form Number	Form Name	Instructions	Revision Date
DMA 632	PE Pregnant Women Medicaid Application	632I	04/14
DMA 632 Page 2	PE Application Page 2		03/14
94A	Healthcare Coverage Application		01/14
94ASP	Healthcare Coverage Application Spanish		01/14
DMA 634	APPROVAL NOTICE OF ACTION	DMA 634i	04/14
DMA 634	DENIAL NOTICE OF ACTION	DMA 634i	04/14
216	ENGLISH DECLARATION OF CITIZENSHIP	216i	01/14
216SP	SPANISH DECLARATION OF CITIZENSHIP		01/14
5460	ENGLISH HIPAA	5460i	08/13
5460SP	SPANISH HIPAA		08/13
	PE Corrections Cover Sheet	MEMO 3/9/12	3/1/12
4/15/13	SSI Pregnant Woman Update		
	QUICK GUIDE ON MEDICAID FOR PREGNANT WOMEN		04/14
DMA 285	Third Party Liability	DMA 285I	01/06

PRESUMPTIVE ELIGIBILITY APPLICATION:

The Presumptive Eligibility Application is used to record information needed to determine PE Medicaid eligibility.

Completion of Individual Items:

Effective for Services Beginning:	Enter application month; enter the first day of the application month; enter the year. No difference if the month name is written out or just the numeric numbers for each month is used. No difference if the full four digits of the year are used or only the last two. As long as the full date is clear.
Medicaid Identification Number:	List her twelve (12) digit number that begins with 111 or 222.
Valid for Listed Month Only:	Enter the month(s) and year in which the Presumptive Eligibility determination was made. Month of application to the end of the completed month.
Applicant's Name:	Enter name of applicant.
Applicant's Maiden Name:	Enter Maiden name of applicant if applicable
Applicant's Mailing Address:	Enter mailing address where card is to be sent. The dwelling isn't required to be fixed. If she is homeless advise her that the DFCS address will be used if she cannot provide an address. This is where her Medicaid card and notifications will be mailed and NET will be set to.
City, State, Zip Code:	Self-explanatory. Must be a GA resident.
County of Residence:	Enter applicant's county of residence even if different from provider's county of residence.
Telephone and SS Number:	Self-explanatory. SSN is optional in that if she can't remember her SSN process the PE application without it. This may cause incorrect duplicate ID numbers.
Patient's Record Number:	For provider's use in identifying patient.
Date of Interview:	Enter month, day and year applicant provided information for form.
Health Insurance:	Yes or No.

Tax Filer Household Non Tax Filer Household:	Enter the filer household per the applicant's statement on what she expects to happen. Enter the applicant's name on the first line. Enter the names of the remaining budget group members on the remaining lines.
Date of Birth:	Enter the birthdates of all budget group members.
Race, Gender and Relationship to Applicant:	Enter for all members of the Budget Group. Tax filer households and non tax filer household budget groups can be very different. *By providing Race information, the applicant will assist us in administering our programs in a non-discriminatory manner. Applicants are not required to give us this information and it will not affect their eligibility or benefit level.
Monthly Gross Taxable Income:	<u>Enter the type of income:</u> C= Commissions OE = Other Earnings P = Pension S = Self Employed OU= Other Unearned Income W = Wage or Salary Refer to Appendix I - Income. <u>Enter amount received and how often:</u> B = Biweekly H = Hourly M = Monthly Q = Quarterly S = Semi-Monthly W = Weekly Y = Yearly D= Daily. Convert all income to a monthly amount.
Monthly Deductions:	Enter all pre-tax and 1040 deductions per budget group member.
Monthly Net Taxable Income:	Enter net taxable income for each budget unit member by subtracting deductions from monthly gross taxable income.

Total Gross Taxable Income:	Enter monthly total gross taxable income for budget group.
Number in Family:	Enter number of persons included in the budget group.
Poverty Level Income:	Enter the amount of the income limit for the budget group size.
Subtotal Net Income:	Enter the monthly total net taxable income for the budget group
5% Deduction:	Enter the 5% deduction based on the budget group size.
Total Family Net Taxable Income:	Enter the amount remaining after the 5% deduction is subtracted from the net taxable income. Compare this amount to the income limit. If the amount is equal to or less than, check the eligible box. If the amount is more, check the ineligible box.
Sworn Statement of Applicant:	Have the applicant sign and date the application after she has read or had read to her the declaration of understanding.
Pregnancy Information:	The provider or designee should assist the applicant to determine her approximate number of weeks pregnant, her expected number of births, and her expected delivery date based on the applicant's statement she is pregnant. No medical verification is requested.
Health Coverage Application	<p>If the applicant has signed/dated the application check the Yes box. If she chooses to submit the application directly to RSM/DFCS check the No box and have the applicant initial.</p> <p>NOTE: The only part of the Health Coverage application that is required, after the completion of a PE application, is the applicant's name, contact information, and sign and date the application. All other information was obtained during the PE application process and any other information needed will be obtained during the post eligibility process by RSM/DFCS. The Health Coverage application is the point the applicant can request any prior month(s) coverage.</p>
Qualified Provider Name:	Full Provider Name.
Qualified Provider ID:	Provider ID number used to complete PE applications on GAMMIS

Qualified Provider Address:	Provider's full mailing address
Direct Phone Number:	The provider's direct phone number of the person that completed the PE application.
Completed By:	The provider's name of the person that completed the PE application
Title:	This provider's title of the person that completed the PE application
Date of completion:	The date the provider completed the PE determination. This date could be different than the actual PE application date.
Signature of Individual completing the form:	The provider's signature of the person that completed the PE application.

Page 2 is to add budget group members if additional lines are needed. This second page can be used for PE Medicaid application forms 632 PE Pregnancy Medicaid. When Page 2 is used it will be included in the PE Packet. All PE Pregnancy Packets will continue to be given to the Right from the Start Medicaid (RSM) Project or the Division of Family and Children Services (DFCS) office: all PE Hospital Packets will be faxed to DCH daily.

EFFECTIVE FOR SERVICES
BEGINNING _____
MONTH DAY YEAR

HP PROVIDER CONTACT CENTER
P.O. BOX 105200
TUCKER, GA 30085-5200

PHONE: 1-800-766-4456
FAX: 1-866-483-1044

MEDICAID IDENTIFICATION NUMBER

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANCY MEDICAID

VALID FOR LISTED MONTH ONLY

APPLICANT'S NAME: _____
APPLICANT'S ADDRESS: _____
APARTMENT/LOT NUMBER: _____
CITY: _____ STATE: _____

MAIDEN NAME: _____
TELEPHONE NUMBER: _____
SOCIAL SECURITY NUMBER: _____
(OPTIONAL)
ZIP CODE: _____ COUNTY OF RESIDENCE: _____

TYPES OF TAXABLE INCOME:
W - WAGES/SALARIES P - PENSION
S - SELF EMPLOYMENT U - UNEMPLOYMENT
OE - OTHER EARNINGS OU - OTHER UNEARNED
HEALTH INSURANCE: YES NO

	TAX FILER HOUSEHOLD <input type="checkbox"/> YES <input type="checkbox"/> NO				DATE OF BIRTH MM/DD/YYYY	GENDER	* RACE	RELATION TO APPLICANT	MONTHLY GROSS TAXABLE INCOME			MONTHLY DEDUCTIONS		MONTHLY NET TAXABLE INCOME
	NON TAX FILER HOUSEHOLD <input type="checkbox"/> YES <input type="checkbox"/> NO								TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	PRE-TAX DEDUCTION	
	FIRST NAME	MI	LAST NAME	SUFFIX										
01								SELF						
02	UNBORN CHILD <input type="checkbox"/> N/A <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6				APPLICANT'S STATEMENT									
03														
04														
05														
06														

SWORN STATEMENT OF APPLICANT:
I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE RIGHT FROM THE START MEDICAID (RSM) PROJECT OR THE COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) OFFICE WILL DETERMINE MY CONTINUING ELIGIBILITY WHEN I SUBMIT A SINGLE STREAMLINED MEDICAID APPLICATION.
I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IMMIGRANT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY HOUSEHOLD, PREGNANCY, RESIDENCY, TAX STATUS AND INCOME.
I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).
I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH THE RSM OR DFCS OFFICE MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY, OR NO LATER THAN THE LAST DAY OF THE FOLLOWING MONTH.
I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS THROUGH WWW.COMPASS.GA.GOV OR CALL 1-877-423-4746 (TDD/TTY 1-800-255-0135); FAX 1-888-740-9355.

TOTAL GROSS TAXABLE INCOME = _____ SUBTOTAL NET INCOME = _____
NUMBER IN BUDGET GROUP = _____ 5 % FPL DEDUCTION = _____
POVERTY INCOME LEVEL = _____ TOTAL NET INCOME = _____
APPLICANT IS ELIGIBLE OR INELIGIBLE FOR RESUMPTIVE ELIGIBILITY MEDICAID
THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY _____ WEEKS PREGNANT WITH _____ FETUS(ES). HER EXPECTED DELIVERY DATE IS _____
I HAVE OBTAINED A SIGNED HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FORWARDED IT TO RSM OR THE COUNTY DFCS OFFICE. YES (Included in PE Packet)
 NO
Applicant's Initials _____
DATE OF COMPLETION _____ COMPLETED BY (PLEASE PRINT) _____ TITLE _____
QP DIRECT PHONE NUMBER _____ SIGNATURE OF QUALIFIED PROVIDER PERSONNEL _____
QUALIFIED PROVIDER NAME AND ADDRESS _____ QUALIFIED PROVIDER ID _____
REIMBURSEMENT FOR MEDICAID SERVICES THROUGH THE PRESUMPTIVE ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL SERVICES OR DELIVERY

DATE OF APPLICATION _____ APPLICANT'S SIGNATURE _____
*By providing Race information, you will assist us in administering our programs in a non-discriminatory manner. You are not required to give us this information and it will not affect your eligibility or benefit level.
DMA 602 (04/01/2014)

SPECIAL NOTE TO BENEFICIARY:

If you have not heard from your county Division of Family and Children Services about your application for Medicaid in fifteen (15) days, please contact that office. You must be approved by the county office to have your baby's delivery paid for by Medicaid or for Medicaid to pay the hospital if you have to be admitted for any reason.

INSTRUCTIONS TO BENEFICIARY:

This certification can be used to receive medical assistance for only the applicant listed on the temporary Medicaid certificate. This certification must be presented to the provider each time medical assistance is requested. You are responsible for this certification. Do not let anyone borrow it. Unlawful use of this card will result in prosecution. If you change your address call the DFCS Call Center or report at www.compass.ga.gov If you lose this certification and/or change your address, contact Member Contact Center. Report insurance coverage to your provider when seeking medical assistance. If you have questions about payment of your medical bills, you may call toll-free 1-866-211-0950.

INSTRUCTIONS TO PROVIDER:

Medical assistance services are to be provided in accordance with the Department of Community Health Plan. Verify eligibility on GAMMIS or by using the IVR system. Certification must be requested each time a service is requested. Always check for other proof of identity. Enter the complete member number as shown for the person receiving the service on the medical assistance claim form. Contact GAMMIS on questions regarding member eligibility.

NOTICE TO OUT OF STATE PROVIDER:

Medical services outside of Georgia require prior approval from the Department of Community Health (DCH) except in the case of emergency or when the health of the beneficiary would be endangered if the services were postponed until return to Georgia. For prior approval, call 1-800-766-4456, from 8:00 A.M. to 7:00 P.M., Monday through Friday.

NOTICE TO BENEFICIARY for Fair Hearings:

Your eligibility under this special program stops when the RSM/DFCS office makes the decision for your continuing eligibility. When you applied for PE Pregnant Women Medicaid, you may also have applied for Health Coverage. When a decision is made on your Medicaid (continuing) eligibility, you will receive a written explanation regarding your continuing eligibility for Medicaid. If you disagree with the decision on your continuing eligibility, you may request a hearing on that decision. Because presumptive eligibility is a temporary Medicaid, you are not entitled to a hearing when your presumptive coverage stops.

FAMILY PLANNING SERVICES:

If you want to plan the number of pregnancies, prevent a pregnancy or get a pregnancy test, contact your doctor, or local Department of Public Health Department family planning information and services. They will be glad to explain various methods of family planning and help you in selecting a method that is best for you.

Family Planning services are available in the Planning for Healthy Babies (P4HB) program.

WIC SERVICES

If you are expecting a baby or already have small children, **WIC** can help you eat better. The Women, Infants and Children program gives food to low-income pregnant women, new mothers and small children. Ask your local Department of Public Health how to qualify for WIC or call 1-800-228-9173.

-If you are going to have a baby, get healthy food, nutrition information and a medical checkup right away. The local Department of Public Health and WIC can help you.

-After the baby is born, stay healthy and give your baby healthy food. Breastfeeding is best for most babies.

-WIC can help you get milk, cheese, eggs, juice, cereal, peanut butter and baby formula.

NOTICE TO BENEFICIARY:

When you applied for PE Pregnant Women Medicaid, you may also have applied for **Health Coverage**. The **Health Coverage** application will be sent to the Division of Family and Children Services (DFCS) office or the Right from the Start Medicaid (RSM) Project. DFCS or RSM will make the decision for your full Medicaid benefits and notify you by mail.

This PE Medicaid coverage is limited to ambulatory prenatal care and does not provide coverage for inpatient hospital and delivery services. You must be approved for full Medicaid benefits in order for the costs of inpatient hospital and delivery services to be covered by the Medicaid program.

Your PE Medicaid coverage ends when a final determination of eligibility is made by the DFCS office or the RSM Project, or no later than the last day of the following month of your PE application.

Health Coverage Application Form 94A

Revised
04/01/14

This 94A form and its attachments are for PE Pregnancy Medicaid Packets **only**. The form 94 is no longer used for PE Pregnancy Medicaid only it has been replaced with the **Health Coverage** application form 94A.

This 94A form is to be included in the PE Pregnancy Medicaid Packet that Qualified Providers/Qualified Hospitals will give to either RSM or DFCS. Do **NOT** mail this form or anything to Albany which is the address located on the last page of the form 94A.

QP/QH are not to incur the expense of printing this form 94A and its attachments. **Until QP/QH receive the 94A forms, and attachments, QP/QH can use the current 94 form and indicate the tax filer and deductions on the form 94.** This information is also needed to complete the revised PE Pregnancy Medicaid Application form DMA 632 so adding this information to the form 94 is information already known to QP/QH.

The only sections required to be completed are

Section 1: Applicant's name and contact information

Section 5 (page 7): Sign and date application

All other information can be obtained during the post eligibility process. The more information they provide the less chance of a delay.

If the applicant states she has unpaid medical bill(s) for any of the retroactive months, Section 2, page 2, **Question 12** should be marked as Yes.

Applicants can also go on line and apply at www.compass.ga.gov

94A and the attachments are in both English and Spanish



Application for Health Coverage & Help Paying Costs

THINGS TO
KNOW



Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
 - A new tax credit that can immediately help pay your premiums for health coverage
 - Free or low-cost insurance from **Medicaid**.
- You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).**



Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Attachment C.



Apply faster online

Apply faster online at Compass.ga.gov.



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family



Why do we ask for this

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**



What happens next?

Send your complete, signed application to the address on page 8. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit Compass.ga.gov or call **1-877-423-4746**. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- **Online:** Compass.ga.gov
- **Phone:** Call our Help Center at **1-877-423-4746**.
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-423-4746** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-877-423-746**.



NEED HELP WITH YOUR APPLICATION? Visit Compass.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

Tell us about yourself.

1

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix			
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number () -		15. Other phone number () -	
16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)?			

Tell us about your family.

2

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.



NEED HELP WITH YOUR APPLICATION? Visit [Compass.ga.gov](https://www.compass.ga.gov) or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

STEP 2: PERSON (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix		2. Relationship to you? SELF
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

5. Social Security number (SSN) _____ - _____ - _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-255-0135.

6. Do you plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a-c. **NO.** If no, skip to question c.

a. Will you file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? Yes No If yes, what is the expected due date / / ; and how many babies are expected? _____

8. Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below. 

NO. If no, SKIP to the income questions on page 3. 
Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

10. Are you a U.S. citizen or U.S. national? Yes No

11. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Have you lived in the U.S. since 1996? Yes No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

12. Do you want help paying for medical bills from the last 3 months? Yes No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? Yes No

14. Are you a full-time student? Yes No

15. Were you in foster care at age 18 or older? Yes No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

17. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
				<input type="checkbox"/> Other _____



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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 18.

Not employed

Skip to question 28.

Self-employed

Skip to question 27.

CURRENT JOB 1:

18. Employer name and address	19. Employer phone number () -
20. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
21. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address	23. Employer phone number () -
24. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
25. Average hours worked each WEEK	

26. **In the past year, did you:** Change jobs Stop working Start working fewer hours Start working more hours None of these

27. **If self-employed, answer the following questions:**

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

_____ \$ _____

28. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

<input type="checkbox"/> None					
<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____
<input type="checkbox"/> Pensions	\$ _____	How often? _____	<input type="checkbox"/> Net rental/royalty	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	<input type="checkbox"/> Other income	\$ _____	How often? _____
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/> Retirement accounts	\$ _____	How often? _____	Type: _____		
<input type="checkbox"/> Alimony received	\$ _____	How often? _____			

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

<input type="checkbox"/> Alimony paid	\$ _____	How often? _____	<input type="checkbox"/> Other deductions	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	\$ _____	How often? _____	Type: _____		

30. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year \$ _____	Your total income next year (if you think it will be different) \$ _____
--	--

THANKS! This is all we need to know about you.



NEED HELP WITH YOUR APPLICATION? Visit Compass.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix _____	2. Relationship to you? _____
3. Date of birth (mm/dd/yyyy) _____	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

5. Social Security number (SSN) _____ - _____ - _____
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? Yes No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
 (You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c. **NO. If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? Yes No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? Yes No If yes, what is the expected due date / / ; and how many babies are expected? _____

9. **Does PERSON 2 need health coverage?**

(Even if they have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below.  **NO. If no**, SKIP to the income questions on page 5.  Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status?

Yes. Fill in their document type and ID number below.

a. Document type _____

b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? Yes No

d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? Yes No

13. Does PERSON 2 want help paying for medical bills from the last 3 months?
 Yes No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child?
 Yes No

15. Was PERSON 2 in foster care at age 18 or older?
 Yes No

Please answer the following questions if PERSON 2 is under the age of 19. Yes No

16. Did PERSON 2 have health insurance and lose it within the past 2 months? Yes No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? Yes No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. **Race (OPTIONAL—check all that apply.)**

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
	<input type="checkbox"/> Chinese			<input type="checkbox"/> Other _____

Now, tell us about any income from PERSON 2 on the back. 



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STEP 2: PERSON 2

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 20.

Not employed

Skip to question 30.

Self-employed

Skip to question 29.

CURRENT JOB 1:

20. Employer name and address	21. Employer phone number () -
22. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
\$ _____	
23. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address	25. Employer phone number () -
26. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
\$ _____	
27. Average hours worked each WEEK	

28. **In the past year, did you:** Change jobs Stop working Start working fewer hours Start working more hours None of these

29. **If self-employed, answer the following questions:**

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

30. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

<input type="checkbox"/> None			<input type="checkbox"/> Net farming/fishing	\$	How often?
<input type="checkbox"/> Unemployment	\$	How often?	<input type="checkbox"/> Net rental/royalty	\$	How often?
<input type="checkbox"/> Pensions	\$	How often?	<input type="checkbox"/> Other income	\$	How often?
<input type="checkbox"/> Social Security	\$	How often?	<input type="checkbox"/>		
<input type="checkbox"/>			Type: _____		
<input type="checkbox"/> Retirement accounts	\$	How often?			
<input type="checkbox"/> Alimony received	\$	How often? _____			

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

<input type="checkbox"/> Alimony paid	\$ _____	How often? _____	<input type="checkbox"/> Other deductions	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	\$ _____	How often? _____	Type: _____		

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income this year	PERSON 2's total income next year (if you think it will be different)
\$ _____	\$ _____

THANKS! This is all we need to know about PERSON 2.



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If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.



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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

- If **No**, skip to Step 4.
- Yes**. If yes, go to Attachment B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

- YES**. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. **NO**.
- | | |
|--|---|
| <input type="checkbox"/> Medicaid: _____ | <input type="checkbox"/> Employer insurance |
| <input type="checkbox"/> PeachCare for Kids® | <input type="checkbox"/> Name of health insurance: |
| <input type="checkbox"/> Medicare _____ | Policy number: |
| <input type="checkbox"/> TRICARE (Don't check if you have direct care or Line of Duty) | Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> VA health care programs _____ | Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Peace Corps _____ | <input type="checkbox"/> Other |
| | Name of health insurance: |
| | Policy number: |
| | Is this a limited-benefit plan (like a school accident policy)? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

- YES**. If yes, you'll need to complete and include Attachment A.
- NO**. If no, continue to Step 5.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



NEED HELP WITH YOUR APPLICATION? Visit [Compass.ga.gov](https://compass.ga.gov) or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

STEP

Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit [Compass.ga.gov](https://compass.ga.gov) or call **1-877-423-4746** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by calling the Georgia Department of Community Health, Office of Inspector General (OIG), Program Integrity Section at 404-463-7590 or toll free at 1-800-533-0686.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Agencies, DFCS, PeachCare for Kids® and the FFM to use income data, including information from tax returns. The Health Insurance Agencies, DFCS, PeachCare for Kids, and the FFM will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? Yes No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Agencies, DFCS, PeachCare for Kids and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS, PeachCare for Kids or the FFM that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at **1-877-423-4746**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Attachment C.

Signature	Date (mm/dd/yyyy)
-----------	-------------------



NEED HELP WITH YOUR APPLICATION? Visit [Compass.ga.gov](https://compass.ga.gov) or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

STEP 6 Mail completed application.

Mail your signed application to the address below:

**Division of Family and Children Services
Customer Contact Center
P.O. Box 4190
Albany, GA 31706**

If you want to register to vote, you can complete a voter registration form at www.sos.ga.gov.

ATTACHMENT A



GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **Job** that offers coverage.

Take the **Employer Coverage Tool** on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the **Employer Coverage Tool**.

EMPLOYEE Information

1. Employee name (First, Middle, Last) _____	2. Employee Social Security number ____-____-____
---	--

EMPLOYER Information

3. Employer name _____	4. Employer Identification Number (EIN) ____-____-____	
5. Employer address _____	6. Employer phone number () - _____	
7. City _____	8. State _____	9. ZIP code _____
10. Who can we contact about employee health coverage at this job? _____		
11. Phone number (if different from above) () - _____	12. Email address _____	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs. a. How much would the employee have to pay in premiums for this plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly
16. What change will the employer make for the new plan year (if known)? <input type="checkbox"/> Employer won't offer health coverage <input type="checkbox"/> Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.) a. How much will the employee have to pay in premiums for that plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly Date of change (mm/dd/yyyy): _____

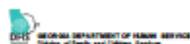
* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



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Form 94a Appendix A (1/14)

EMPLOYER COVERAGE TOOL



Form Approved
OMB No. 0938-1191

Use this tool to help answer questions in Attachment A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Attachment A. For example, the answer to question 14 on this page should match question 14 on Attachment A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.



EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number ____-____-____
--	---



EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) ____-____	
5. Employer address	6. Employer phone number () -	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) () -	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)

No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



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Form 94a Appendix A (1/14)

ATTACHMENT B



GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

American Indian or Alaska Native Family Member (AI/AN)

Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
	First	Middle	First	Middle
1. Name (First name, Middle name, Last name)	Last		Last	
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No		<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance 	\$ _____ How often? _____		\$ _____ How often? _____	



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Form 94a Appendix B (1/14)

ATTACHMENT C



GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Division of Family and Children Services (DFCS) at 1-877-423-4746. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)



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Form 94a Appendix C (1/14)



Solicitud para Cobertura de Salud y Ayuda Pagando el Costo

Formulario aprobado
OMB Num. 0938-1191

COSAS PARA SABER



Use esta solicitud para ver cuáles opciones de cobertura usted califica

- Plan de seguro de salud privado o económico que ofrece cobertura integral que le ayuda a mantenerse bien
 - Un nuevo crédito tributario que puede ayudarlo inmediatamente a pagar sus primas de cobertura de salud
 - Seguro de Medicaid gratis o a bajo costo.
- Usted puede calificar para un programa gratis o a bajo costo aunque usted gane tanto como \$94,000 al año (para una familia de cuatro).**



¿Quién puede usar esta Solicitud?

- Use esta solicitud para solicitar para cualquier persona en su familia.
- Solicite aunque usted o su hijo(a) ya estén cubiertos. Usted podría ser elegible para una cobertura gratis o a un costo más bajo.
- Si usted es soltero(a), podría usar el formulario corto. Visite HealthCare.gov.
- Las familias que tienen inmigrantes pueden solicitar. Usted puede solicitar para su hijo(a) aunque usted no sea elegible para cobertura. Solicitar no afectará su estado migratorio o su oportunidad de convertirse en residente permanente o ciudadano(a).
- Si alguien le está ayudando a llenar esta solicitud, usted podría necesitar completar el Anejo C.



Solicite más rápido en línea

Solicite más rápido en línea Compass.ga.gov.



Qué necesita para solicitar

- Números de Seguro Social (o el número de documento para cualquier inmigrante legal que necesite seguro)
- Información del empleador y de ingresos para todos en su familia (por ejemplo, talones de cheque, formularios W-2, o declaraciones de sueldo y tributarias)
- Números de póliza para cualquier seguro de salud actual
- Información sobre cualquier seguro de salud relacionado con el empleo que esté disponible para su familia



¿Por qué pedimos esta

Pedimos la información sobre ingresos y otra información para dejarle saber para qué cobertura usted podría calificar y para ver si puede recibir ayuda para pagar el mismo. **Vamos a mantener toda la información que nos proporcione de manera segura y confidencial, como es requerido por ley.**



¿Qué pasa después?

Envíe su solicitud completa y firmada a la dirección que aparece en la página 8. **Si no tiene toda la información que pedimos, firméla y preséntela de todas maneras.** Nosotros haremos un seguimiento con usted dentro de 1 a 2 semanas. Usted recibirá instrucciones sobre los siguientes pasos necesarios para completar su cobertura de salud. Si no recibe ninguna noticia de nosotros, visite Compass.ga.gov o llame al 1-877-423-4746. Llenar esta solicitud no quiere decir que usted tenga que comprar cobertura de salud.



Consiga ayuda para hacer esta solicitud

- **En línea:** Compass.ga.gov
- **Teléfono:** Llame a nuestro Centro de Ayuda al 1-877-423-4746.
- **En persona:** Es posible que en su área hayan consejeros que le puedan ayudar. Para mayor información, visite nuestro sitio web o llame al 1-877-423-4746.
- **En español:** Llame a nuestro centro de ayuda gratis al 1-877-423-4746.



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

Form 94a (Rev. 1/14) - Spanish

Paso 1: Cuéntenos sobre usted.

(Necesitamos que un adulto de la familia sea la persona de contacto para su solicitud.)

1. Primer nombre, segundo nombre, Apellido, & Sufijo			
2. Dirección de domicilio (Deje en blanco si no tiene una.)			3. Número del apartamento o suite
4. Ciudad	5. Estado	6. Código postal	7. Condado
8. Dirección postal (si es distinta a de domicilio):			9. Número del apartamento o suite
10. Ciudad	11. Estado	12. Código postal	13. Condado
14. Número de teléfono () -		15. Otro número de teléfono () -	
16. ¿Quiere recibir información por correo electrónico sobre esta solicitud? <input type="checkbox"/> Sí <input type="checkbox"/> No Dirección de correo electrónico: _____			
17. ¿En qué idioma prefiere hablar o escribir (si no es el inglés)?			

Paso 2: Cuéntenos sobre su familia.

¿A quién(es) necesita incluir en esta solicitud?

Cuéntenos sobre todos los familiares que viven con usted. Si presenta una declaración de impuestos, tenemos que saber sobre todos los que aparecen en su declaración de impuestos. (No necesita presentar una declaración de impuestos para obtener una cobertura de salud).

Incluya:

- Usted mismo(a)
- Su cónyuge
- Sus hijos(as) menores de 21 años que viven con usted
- Su pareja sin casarse que necesite cobertura de salud
- Cualquier persona que usted incluya en su declaración de impuestos, aún si no viven con usted
- Cualquier persona menor de 21 años que esté a su cargo y que viva con usted

NO tiene que incluir:

- Su pareja sin casarse que no necesite cobertura de salud
- Los hijos de su pareja sin casarse
- Sus padres que viven con usted, pero que hacen su propia declaración de impuestos (si usted tiene más de 21 años de edad)
- Otros familiares adultos que presentan sus propias declaraciones de impuestos

La cantidad de asistencia o el tipo de programa para el que califique depende del número de personas en su familia y sus ingresos. Esta información nos ayuda a asegurarnos de que todos obtengan la mejor cobertura posible.

Complete el paso 2 para cada persona en su familia. Empiece con usted y luego añada a otros adultos y menores. Si tiene más de 2 personas en su familia, necesitará hacer una copia de las páginas y ponerlas adjunto. Usted no tiene que proveer el estado migratorio o número de Seguro Social (SSN) para los miembros de la familia que no necesitan cobertura de salud. Mantendremos toda la información que provea de manera privada y segura como es requerido por ley. Usaremos la información personal sólo para verificar si es elegible para cobertura de salud.



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

Form 94a (Rev. 1/14) - Spanish

Página 1 de 8

PASO 2: PERSONA 1 (empiece con usted mismo(a))

Complete el paso 2 para usted mismo(a), su cónyuge/pareja e hijos(as) que vivan con usted y cualquier otra persona en su declaración federal de impuestos, si usted rinde una declaración de impuestos. Vea la 1ra página para más información sobre a quién incluir. Si usted no presenta una declaración de impuestos, recuerde añadir a los miembros de su familia que vivan con usted.

1. Primer nombre, segundo nombre, Apellido, Sufijo

2. Parentesco con usted
USTED MISMO

3. Fecha de nacimiento (MM/DD/AAAA):

4. Sexo Masculino Femenino

5. Número de Seguro Social (SSN) _____ - _____ - _____

Necesitamos esto si quiere cobertura de salud y tiene un Número de Seguro Social. Proveer su SSN puede ayudar aunque no quiera cobertura de salud ya que puede ayudar a acelerar el proceso de solicitud. Usamos los números de Seguro Social para verificar los ingresos y otra información para ver quién es elegible para ayuda con el costo de cobertura de salud. Si alguien quiere ayuda para obtener un SSN, llame al 1-800-772-1213 o visite socialsecurity.gov. Los usuarios de TTY deben llamar al 1-800-255-0135.

6. ¿Planea presentar una declaración de impuesto federal el PRÓXIMO AÑO?

(Aunque no presente una declaración de impuestos, usted puede solicitar para seguro de salud.)

SÍ. Si sí, por favor, conteste las preguntas a–c. **NO. Si no,** salte a la pregunta c.

a. ¿Va a declarar conjunto con su cónyuge? Sí No

Si sí, nombre del cónyuge: _____

b. ¿Va a reclamar algún dependiente en su declaración de impuestos? Sí No

Si sí, haga una lista del (los) dependiente(s): _____

c. ¿Será usted reclamado(a) como un(a) dependiente en la declaración de impuestos de otra persona? Sí No

Si sí, por favor mencione el nombre del declarante de impuestos: _____

¿Cuál es su parentesco con el declarante de impuestos? _____

7. ¿Está embarazada? Sí No Si sí, ¿cuál es la fecha esperada de alumbramiento __/__/__; y cuantos bebés está esperando? _____

8. ¿Necesita cobertura de salud?

(Aunque tenga seguro, puede haber un programa con mejor cobertura o un costo más bajo.)

SÍ. Si sí, conteste todas las preguntas abajo.  **NO. Si no,** salte a las preguntas sobre ingresos en la página 3. 
Deje el resto de esta página en blanco

9. ¿Tiene una condición física, mental o de salud emocional que le cause limitaciones en actividades (como bañarse, vestirse, actividades diarias, etc) o vive en un centro médico o un hogar ancianos? Sí No

10. ¿Es usted un(a) ciudadano(a) de los Estados Unidos o nacional de los Estados Unidos? Sí No

11. Si usted no es ciudadano(a) o nacional de los Estados Unidos, ¿es un inmigrante calificado?

Sí. Llene la información de su tipo de documento y número de ID abajo.

a. Tipo de documento de inmigración _____ b. Número de ID de documento _____

c. ¿Ha vivido usted en los Estados Unidos desde el 1996? Sí No d. ¿Es usted o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? Sí No

12. ¿Usted quiere ayuda para pagar facturas médicas de los últimos tres meses? Sí No

13. ¿Vive usted con al menos un menor de 19 años y usted es el cuidador(a) principal de este menor? Sí No

14. ¿Es usted un estudiante a tiempo completo? Sí No 15. ¿Estuvo usted en cuidado tutelar a la edad de 18 años o mayor? Sí No

16. Si es hispano/latino (OPCIONAL—marque todas las que aplican.)

Mexicano Mexicanoamericano Chicano Puertorriqueño Cubano Otro _____

17. Raza (OPCIONAL—marque todas las que aplican.)

Blanco Indígena estadounidense Filipino Vietnamita De Guam o chamorros
o de Alaska
 Negro o afroamericano De la India Japonés Otro asiático De Samoa
 Chino Coreano Indígena de Hawái De otra isla del Pacífico
 Otro



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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PASO 2: PERSONA 1 (Continúe con usted mismo(a))

Trabajo actual e Información de ingresos

- Empleado**
 Si está empleado actualmente, díganos sobre sus ingresos. Empezee con la pregunta 18.
- No empleado**
 Salte a la pregunta 28.
- Trabajo por cuenta propia**
 Salte a la pregunta 27.

TRABAJO ACTUAL 1:

18. Nombre y dirección del empleador	19. N° de teléfono del empleador () -
20. Sueldos/propinas (antes de impuestos) <input type="checkbox"/> por hora <input type="checkbox"/> semanal <input type="checkbox"/> cada dos semanas <input type="checkbox"/> quincenal <input type="checkbox"/> mensual <input type="checkbox"/> anual	
\$ _____	
21. Promedio de horas trabajadas cada SEMANA	

TRABAJO ACTUAL 2: (Si tiene más trabajos y necesita más espacio, adjunte otra hoja de papel.)

22. Nombre y dirección del empleador	23. N° de teléfono del empleador () -
24. Sueldos/propinas (antes de impuestos) <input type="checkbox"/> por hora <input type="checkbox"/> semanal <input type="checkbox"/> cada dos semanas <input type="checkbox"/> quincenal <input type="checkbox"/> mensual <input type="checkbox"/> anual	
\$ _____	
25. Promedio de horas trabajadas cada SEMANA	

26. **El año pasado,** ¿cambio de trabajo? ¿dejó de trabajar? ¿empezó a trabajar menos horas? ¿empezó a trabajar más horas? Ninguno

27. Si trabaja por cuenta propia, conteste las siguientes preguntas:

a. tipo de trabajo

b. ¿Cuánto ingresos netos (ganancias una vez se hayan pagado los gastos del negocio) recibirá de su trabajo por cuenta propia este mes?

_____ \$ _____

28. OTRO INGRESO: Marque todas las que apliquen y dé la cantidad y cada cuanto la recibe.

NOTA: Usted no necesita decirnos sobre los ingresos de manutención infantil, pagos de veterano o Ingresos del Seguro Suplementario.

- Ninguno
 desempleo \$ _____ ¿Con qué _____
 Pensiones \$ _____ ¿Con qué _____
 Seguro Social \$ _____ ¿Con qué _____
 Cuentas de retiro \$ _____ ¿Cada cuánto? _____
 Pensión alimenticia \$ _____ ¿Cada cuánto? _____
- Cantidad neta de pesca y cultivos \$ _____ ¿Frecuencia? _____
 Renta/regalías netas \$ _____ ¿Frecuencia? _____
 Otro ingreso \$ _____ ¿Frecuencia? _____
 Tipo: _____

29. DEDUCCIONES Marque todas las que aplican y dé la cantidad y cada cuánto la paga.

Si paga por ciertas cosas que pueden ser deducidas en la declaración de impuestos federales y nos deja saber, su costo de cobertura de salud pudiera ser un poco menos.

NOTA: No debe incluir los costos netos que ya declaró en su respuesta de trabajo por cuenta propia (pregunta 27b).

- pensión alimenticia \$ _____ ¿Cada cuánto? _____
 Intereses del préstamos estudiantil \$ _____ ¿Cada cuánto? _____
 Otras deducciones \$ _____ ¿Cada cuánto? _____
 Tipo: _____

30. INGRESO ANUAL: Complete sólo si sus ingresos cambian cada mes. Sino espera cambios en sus ingresos mensuales, salte a la próxima persona.



Su total de ingresos este año	El total de sus ingresos el próximo año (si piensa que será diferente)
\$ _____	\$ _____

¡GRACIAS! Es todo lo que necesitamos saber de usted.



¿Necesita ayuda con su solicitud? Visite Compass.ca.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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PASO 2: PERSONA 2

Complete el paso 2 para usted mismo(a), su cónyuge/pareja e hijos(as) que vivan con usted y cualquier otra persona en su declaración federal de impuestos, si usted rinde una declaración de impuestos. Vea la 1ra página para más información sobre a quién incluir. Si usted no presenta una declaración de impuestos, recuerde añadir a los miembros de su familia que vivan con usted.

1. Primer nombre, segundo nombre, Apellido, Sufijo _____ 2. Parentesco con usted _____

3. Fecha de nacimiento (MM/DD/AAAA): _____ 4. Sexo Masculino Femenino

5. Número de Seguro Social (SSN) _____ - _____ - _____
Necesitamos esto si quiere cobertura de salud y tiene un Número de Seguro Social

6. ¿Vive con usted la PERSONA # 2? Sí No
 Síno, escriba la dirección: _____

7. ¿La PERSONA # 2 planea presentar una declaración de impuestos el PRÓXIMO AÑO?
 (Aunque no presente una declaración de impuestos, usted puede solicitar para seguro de salud)

SÍ. Si sí, por favor, conteste las preguntas a-c. **NO. Si no**, salte a la pregunta c.

a. ¿La PERSONA # 2 presentará una declaración de impuestos con un cónyuge? Sí No
 Si sí, nombre del cónyuge: _____

b. ¿La PERSONA # 2 va a reclamar algún dependiente en su declaración de impuestos? Sí No
 Si sí, haga una lista del (los) dependiente(s): _____

c. ¿Será la PERSONA # 2 reclamada como un(a) dependiente en la declaración de impuestos de otra persona? Sí No
 Si sí, por favor mencione el nombre del declarante de impuestos: _____
 ¿Cuál es el parentesco de la PERSONA # 2 con el declarante de impuestos? _____

8. ¿Está embarazada la PERSONA # 2? Sí No a. Si sí, ¿cual es la fecha esperada de alumbramiento __/__/__; y cuantos bebés está esperando? _____

9. ¿Necesita cobertura de salud la PERSONA # 2?
 (Aunque tenga seguro, puede haber un programa con mejor cobertura o un costo más bajo.)

SÍ. Si sí, conteste todas las preguntas abajo.  **NO. Si no**, salte a las preguntas sobre ingresos en la página 5 . Deje el resto de esta página en blanco.

10. ¿Tiene la PERSONA # 2 una condición física, mental o de salud emocional que le cause limitaciones en actividades (como bañarse, vestirse, actividades diarias, etc) o vive en un centro médico o un hogar de ancianos? Sí No

11. ¿Es la PERSONA # 2 un(a) ciudadano(a) de los Estados Unidos o nacional de los Estados Unidos? Sí No

12. Si la PERSONA # 2 no es ciudadano(a) o nacional de los Estados Unidos, ¿es un inmigrante calificado?

SÍ. Llene la información de su tipo de documento y número de ID abajo.

a. Tipo de documento de inmigración _____ b. Número de ID de documento _____

c. ¿Ha vivido la PERSONA # 2 en los Estados Unidos desde el 1996? Sí No d. ¿Es la PERSONA # 2 o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? Sí No

13. ¿La PERSONA # 2 quiere ayuda para pagar facturas médicas de los últimos tres meses? <input type="checkbox"/> Sí <input type="checkbox"/> No	14. ¿Vive la PERSONA # 2 con al menos un menor de 19 años y usted es el cuidador(a) principal de este menor? <input type="checkbox"/> Sí <input type="checkbox"/> No	15. ¿Estuvo la PERSONA # 2 en cuidado tutelar a la edad de 18 o mayor? <input type="checkbox"/> Sí <input type="checkbox"/> No
--	---	---

Por favor, conteste las siguientes preguntas si la PERSONA # 2 es menor de 19 años.

16. ¿Tuvo la PERSONA # 2 seguro de salud y lo perdió en los últimos dos meses? Sí No
 a. Si sí, fecha en que terminó: _____ b. Razón por la cual terminó el seguro: _____

17. ¿Es la PERSONA # 2 un estudiante de tiempo completo? Sí No

18. Si es hispano/latino (OPCIONAL—marque todas las que aplican.)
 Mexicano Mexicanoamericano Chicano Puertorriqueño Cubano Otro _____

19. Raza (OPCIONAL—marque todas las que aplican.)

<input type="checkbox"/> blanco	<input type="checkbox"/> indio-americano o nativo de Alaska	<input type="checkbox"/> filipino	<input type="checkbox"/> vietnamita	<input type="checkbox"/> de Guam o Chamorro
<input type="checkbox"/> negro o africano	<input type="checkbox"/> indio asiático	<input type="checkbox"/> japonés	<input type="checkbox"/> otro asiático	<input type="checkbox"/> de Samoa
<input type="checkbox"/> estadounidense	<input type="checkbox"/> chino	<input type="checkbox"/> coreano	<input type="checkbox"/> nativo de Hawái	<input type="checkbox"/> de otras Islas del Pacífico
				<input type="checkbox"/> Otro _____

Ahora, díganos sobre cualquier tipo de Ingresos de la PERSONA # 2 en la parte de atrás. 

 ¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

PASO 2: PERSONA 2

Trabajo actual e Información de ingresos

Empleado

Si está empleado actualmente, díganos sobre sus ingresos. Empiece con la pregunta 20.

No empleado

Salte a la pregunta 30.

Trabajo por cuenta propia

Salte a la pregunta 29.

TRABAJO ACTUAL 1:

20. Nombre y dirección del empleador _____ 21. N° de teléfono del empleador
() -

22. Sueldos/propinas (antes de impuestos) por hora semanal cada dos semanas quincenal mensual anual

\$ _____

23. Promedio de horas trabajadas cada SEMANA _____

TRABAJO ACTUAL 2: (Si tiene más trabajos y necesita más espacio, adjunte otra hoja de papel.)

24. Nombre y dirección del empleador _____ 25. N° de teléfono del empleador
() -

26. Sueldos/propinas (antes de impuestos) por hora semanal cada dos semanas quincenal mensual anual

\$ _____

27. Promedio de horas trabajadas cada SEMANA _____

26. **El año pasado,** ¿cambio de trabajo? ¿dejó de trabajar? ¿empezó a trabajar menos horas? ¿empezó a trabajar más horas? Ninguno

29. Si trabaja por cuenta propia, conteste las siguientes preguntas:

a. tipo de trabajo _____

b. ¿Cuánto ingresos netos (ganancias una vez se hayan pagado los gastos del negocio) recibirá de su trabajo por cuenta propia este mes?

\$ _____

30. OTRO INGRESO: Marque todas las que apliquen y dé la cantidad y cada cuánto la recibe.

NOTA: Usted no necesita decirnos sobre los ingresos de manutención infantil, pagos de veterano o Ingresos del Seguro Suplementario.

Ninguno desempleo \$ _____ ¿Con qué _____ Cantidad neta de pesca y cultivos \$ _____ ¿Frecuencia? _____
 Pensiones \$ _____ ¿Con qué _____ Renta/regalías netas \$ _____ ¿Frecuencia? _____
 Seguro Social \$ _____ ¿Con qué _____ Otro ingreso \$ _____ ¿Frecuencia? _____
 Cuentas de retiro \$ _____ ¿Cada cuánto? _____ Tipo: _____
 Pensión alimenticia \$ _____ ¿Cada cuánto? _____

31. DEDUCCIONES Marque todas las que aplican y dé la cantidad y cada cuánto la paga.

Si la PERSONA # 2 paga por ciertas cosas que pueden ser deducidas en la declaración de impuestos federales y nos deja saber, su costo de cobertura de salud pudiera ser un poco menos.

NOTA: No debe incluir los costos netos que ya declaró en su respuesta de trabajo por cuenta propia (pregunta 29b)

pensión alimenticia \$ _____ ¿Cada cuánto? _____ Otras deducciones \$ _____ ¿Cada cuánto? _____
 Intereses del préstamos estudiantil \$ _____ ¿Cada cuánto? _____ Tipo: _____

32. INGRESO ANUAL: Complete solo si los ingresos de la PERSONA # 2 cambian cada mes.

Si no espera cambios en ingresos mensuales de la PERSONA # 2, agregue otra persona o salte a la próxima sección.

Total de ingresos **este año** para la PERSONA # 2 _____ El total de ingresos el **próximo año** para la PERSONA # 2 (si piensa que será diferente)
 \$ _____ \$ _____

¡GRACIAS! Es todo lo que necesitamos saber de la PERSONA # 2.

Si tiene más de dos personas que incluir, haga una copia del paso 2: Persona # 2 (páginas 4 y 5) y complete.

? ¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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PASO 3 Familiares de indios americanos o nativos de Alaska (AI/AN, por sus siglas en inglés)

1. ¿Es usted o alguien en su familia indio americano o nativo de Alaska?

- Si No, salte al paso 4.
 Sí. Si sí, vaya al anejo B.

PASO 4 La cobertura de salud de su familia

Conteste estas preguntas para cualquiera que necesite cobertura de salud.

1. ¿Hay alguien inscrito en algunas de las siguientes coberturas de salud?

- Sí. Si sí, verifique el tipo de cobertura y escriba el nombre de la persona al lado del tipo de cobertura que tienen. NO.

Medicaid: _____

PeachCare for Kids® _____

Medicare _____

TRICARE (No marque si tiene cuidado directo o Line of Duty) _____

Programas de cuidado de salud de Veteranos _____

Peace Corps _____

Seguro del empleador _____

Nombre del seguro de salud: _____

Número de póliza: _____

¿Es esta una cobertura de COBRA? Sí No

¿Es éste un plan de salud de jubilación? Sí No

Otro

Nombre del seguro de salud: _____

Número de póliza: _____

¿Es éste un plan con beneficios limitados (como una póliza escolar de accidente)? Sí No

2. ¿A alguien listado en esta solicitud le han ofrecido una cobertura de salud de un trabajo? Marque Sí aunque la cobertura sea del trabajo de otra persona como un padre (madre) o cónyuge.

- Sí. Si sí, necesitará completar e incluir el anejo A.
 NO. Si no, continúe al paso 5.

PRA Cláusula de Divulgación

De acuerdo con La Ley de Reducción de Papeleo del 1995, ninguna persona es requerida a responder a una serie de información a menos que exponga un número de control OMB válido. El número de control OMB válido para esta serie de información es 0938-1191. El tiempo que se necesita para completar esta recaudación de información se estima en un promedio [Indique el tiempo (horas o minutos)] por respuesta, incluido el tiempo de revisar las instrucciones, buscar las fuentes de información existentes, reunir la información necesaria y completar y revisar la recaudación de la información. Si tiene comentarios relacionados a la exactitud del estimado de tiempo o sugerencias de como mejorar este formulario, por favor escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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PASO 5

Lea y firme esta solicitud.

- Estoy firmando esta solicitud bajo pena de perjurio lo que significa que he proporcionado respuestas verdaderas a todas las preguntas en este formulario según mi leal saber y entender. Sé que puedo estar sujeto a penalizaciones bajo la ley federal si proporciono información falsa o no verdadera.
- Debe informar de dichos cambios dentro de los 10 días calendarios siguientes a la fecha en que ocurra el cambio. Puedo visitar Compass.ga.gov o llamar al **1-877-423-4746** para informar cualquier cambio. Entiendo que un cambio de mi información podría afectar la elegibilidad para los miembros de mi hogar.
- Entiendo que bajo la ley federal, no se permite discriminación por motivos de raza color de piel, origen nacional, sexo, edad, orientación sexual, identidad de género o discapacidad. Puedo presentar una queja de discriminación llamando al Denunciante de Georgia, la Oficina del Inspector General (OIG), el Programa de Sección de Integridad al 404-463-7590 o sin costo alguno al 1-800-533-0686.
- Confirmando que nadie solicitando seguro de salud en esta solicitud está encarcelado (detenido o en prisión). Si no, _____ está encarcelado.
(nombre de la persona)

Necesitamos esta información para verificar su elegibilidad para ayuda pagando cobertura de salud si decide solicitar. Vamos a verificar sus respuestas usando la información en nuestra base de datos electrónica y la base de datos del Servicio de Impuestos Internos (IRS), el Seguro Social, el Departamento del Trabajo (DOL), TALX (el número de identificación del trabajo), el Departamento de Seguridad Nacional y/o una agencia de información crediticia del consumidor. Si la información no concuerda, podríamos pedirle que nos envíe verificación.

Renovación de cobertura en los próximos años

Para facilitar mi elegibilidad para ayuda pagando por cobertura de salud en años futuros, estoy de acuerdo en permitir a las Agencias de Seguro de Salud, DFCS, PeachCare for Kids® y el Mercado Facilitado Federal (FFM, por sus siglas en inglés) para usar los datos de ingresos, incluyendo la información de las declaraciones de impuestos. Las Agencias de Seguro de Salud, DFCS, PeachCare for Kids, y la FFM me enviará un aviso, me permitirá hacer cualquier cambio y puedo optar por no participar en cualquier momento.

Sí, renueve mi elegibilidad automáticamente por los próximos

5 años (el máximo número de años permitido), o por una menor cantidad de años:

4 años 3 años 2 años 1 año No use la información de mi declaración de impuestos para renovar mi cobertura.

Si alguien en esta solicitud es elegible para Medicaid

- Le doy a la agencia de Medicaid nuestros derechos de buscar y conseguir cualquier dinero de otras seguros de salud, acuerdos legales u otros terceros participantes. También le doy a la agencia de Medicaid los derechos de buscar y conseguir apoyo médico de un cónyuge o padre (madre).
- ¿Hay algún menor en esta solicitud que tenga un padre (madre) viviendo fuera del hogar? Sí No
- Si sí, sé que se me pedirá que coopere con la agencia que cobra apoyo médico de un padre (madre) ausente. Si pienso que tener que cooperar para cobrar apoyo médico me hará daño a mí o a mis hijos(as), le puedo dejar saber a Medicaid y podría no tener que cooperar.

Mi derecho a apelar

Si pienso que las Agencias de Seguro de Salud, DFCS, PeachCare for Kids y las FFM han cometido un error, puedo apelar su decisión. Apelar significa decirle a alguien en las Agencias de Seguro de Salud, DFCS, PeachCare for Kids o el FFM que pienso que la acción tomada está equivocada y pedir para una revisión justa de la acción. Sé que puedo enterarme de cómo apelar comunicándome con la División de Servicios para Familia y Niños (DFCS) al **1-877-423-4746**. Sé que puedo ser representado(a) en este proceso por otra persona que no sea yo. Mi elegibilidad y otra información importante me será explicada.

Firme esta solicitud. La persona que llene el Paso 1 debe firmar esta solicitud. Si usted es un representante autorizado, puede firmar aquí siempre y cuando haya proporcionado la información requerida en el Anejo C.

Firma	Fecha (mm/dd/aaaa)
-------	--------------------



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en español, llame al **1-877-423-4746**. Si necesita ayuda en algún idioma que no sea inglés, llame al **1-877-423-4746** y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al **1-800-255-0135**.

Form 94a (Rev. 1/14) - Spanish

Página 7 de 8

PASO 6 Envíe la solicitud completa.

Envíe su solicitud firmada a la dirección abajo:

**Division of Family and Children Services
Customer Contact Center
P.O. Box 4190
Albany, GA 31706**

Si quiere registrarse para votar, puede completar un formulario de registro electoral en www.sos.ga.gov.



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en español, llame al **1-877-423-4746**. Si necesita ayuda en algún idioma que no sea inglés, llame al **1-877-423-4746** y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al **1-800-255-0135**.

Form 94a (Rev. 1/14) - Spanish

Página 8 de 8

ANEXO A



DEPARTAMENTO DE SERVICIOS HUMANOS DE GEORGIA
División de Servicios para Familias y Niños



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Cobertura de salud de los trabajos

Usted **NO** tiene que contestar estas preguntas a menos que alguien en su hogar sea elegible para recibir cobertura de salud por el trabajo. Adjunte una copia de esta página para cada trabajo que ofrezca cobertura.

Cuéntenos sobre el trabajo que ofrece la cobertura.

Para ayudarlo a contestar estas preguntas lleve la Herramienta de Cobertura del Empleador, que aparece en la siguiente página, al empleador que ofrece la cobertura. Cuando envíe su solicitud, sólo tiene que incluir esta página, no la Herramienta de Cobertura del Empleador.

Información sobre el EMPLEADO

1. Nombre del empleado (Nombre de pila, del Medio, Apellido)	2. Número de la Seguridad Social del empleado ____-____-____
--	---

Información sobre el EMPLEADOR

3. Nombre del empleador	4. Número de Identificación del Empleador (EIN) ____-____-____		
5. Dirección del empleador	6. Número de teléfono del empleador () - _____		
7. Ciudad	8. Estado	9. Código postal	
10. ¿A quien podemos llamar para hablar sobre la cobertura de salud del empleado en este trabajo?			
11. No. teléfono (si es diferente al de arriba) () - _____	12. Dirección de correo electrónico		

13. ¿Ud. es actualmente elegible para recibir la cobertura ofrecida por este empleador, o va a ser elegible en los próximos 3 meses?

Sí (Continúe)

13a. Si está en un período de espera o de prueba, ¿cuándo podrá inscribirse para tener cobertura? _____
(mm/dd/aaaa)

Liste los nombres de cualesquiera otras personas que sean elegibles para recibir cobertura por parte de este trabajo.

Nombre: _____ Nombre: _____ Nombre: _____

No (Pare aquí y vaya al Paso 5 de la solicitud)

Cuéntenos sobre el plan de salud ofrecido por este empleador.

14. ¿El empleador ofrece un plan de salud que satisface el estándar del valor mínimo* Sí No

15. Para el plan de salud más barato que satisfaga el estándar del valor mínimo* ofrecido **sólo al empleado** (no incluya planes familiares): Si el empleador tiene programas de bienestar, proporcione la prima que el empleado tendría que pagar si él/ ella recibiera el máximo descuento por cualesquiera programas para dejar de fumar, y si no recibiera ningún otro descuento basado en los programas de bienestar.

a. ¿Cuánto, en primas, tendría que pagar el empleado por este plan? \$ _____

b. ¿Con qué frecuencia? Semanal Cada 2 semanas 2 veces al mes Mensual Trimestral Anual

16. ¿Qué cambio hará el empleador para el nuevo año del plan (si se sabe)?

El empleador no ofrecerá cobertura de salud

El empleador comenzará a ofrecer una cobertura de salud a los empleados o a cambiar las primas para el plan más barato disponible, solamente para el empleado, que satisfaga el estándar del valor mínimo.* (La prima debe reflejar el descuento por los programas de bienestar. Vea la pregunta 15.)

a. ¿Cuánto, en primas, tendrá que pagar el empleado por ese plan? \$ _____

b. ¿Con qué frecuencia? Semanal Cada 2 semanas 2 veces al mes Mensual Trimestral Anual

Fecha del cambio (mm/dd/aaaa): _____

* Un plan de salud patrocinado por el empleador satisface el "estándar del valor mínimo" si la porción del plan, del costo total del beneficio cubierto por el plan, es no menos del 60% de dichos costos (Sección 36B(c)(2)(C)(ii) del Código de Recaudación Interna de 1986)



¿NECESITA AYUDA CON SU SOLICITUD? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en Español, llame al 1-877-423-4746. Si necesita ayuda en otro idioma que no sea el inglés, llame al 1-877-423-4746 y dígame al representante del servicio al cliente qué idioma necesita. Nosotros le conseguiremos ayuda gratis. Los usuarios de TTY deben llamar al 1-800-255-0135.

Form 94a Appendix A (1/14)

HERRAMIENTA DE COBERTURA DEL EMPLEADOR



DEPARTAMENTO DE SERVICIOS SOCIALES DE MISSOURI
Missouri Department of Social Services



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Form Approved
OMB No. 0938-1191

Use esta herramienta para ayudar a contestar las preguntas del Anexo A sobre cualquier cobertura de salud del empleador para la cual usted es elegible (aún si es por el trabajo de otra persona, como de un padre o esposo). La información que aparece en las casillas numeradas que siguen corresponde a las casillas del Anexo A. Por ejemplo, la respuesta a la pregunta 14 de esta página debe corresponder a la pregunta 14 del Anexo A.

Escriba su nombre y número de Seguridad Social en las casillas 1 y 2 y pídale al empleador que llene el resto del formulario. Complete una herramienta para cada empleador que ofrece cobertura de salud.



Información sobre el EMPLEADO

El empleado tiene que llenar esta sección.

1. Nombre del empleado (Nombre de pila, del Medio, Apellido)	2. No. de Seguridad Social
--	----------------------------



Información sobre el EMPLEADOR

Pídale al empleador esta información.

3. Nombre del empleador	4. No. de identificación del empleador (EIN)	
5. Dirección del empleador	6. Número de teléfono del empleador () -	
7. Ciudad	8. Estado	9. Código postal
10. ¿A quién podemos contactar para hablar sobre la cobertura de salud del empleado en este trabajo?		
11. No. de teléfono (si es diferente al de arriba) () -	12. Dirección de correo electrónico	

13. ¿El empleado es actualmente elegible para la cobertura ofrecida por este empleador, o va ser elegible en los próximos 3 meses?

Sí (Continúe)

13a. Si el empleado no es elegible el día de hoy, incluyendo como resultado de un período de espera o de prueba, ¿cuándo va el empleado a ser elegible para la cobertura? (mm/dd/aaaa) (Continúe)

No (PARE y devuelva este formulario al empleado)

Cuéntenos sobre el plan de salud ofrecido por este empleador.

¿El empleador ofrece un plan de salud que cubre al cónyuge o dependiente del empleado?

Sí. ¿A quién? Cónyuge Dependiente(s)

No

(Vaya a la pregunta 14)

14. ¿El empleador ofrece un plan de salud que satisface el estándar del valor mínimo*?

Sí (Vaya a la pregunta 15) No (PARE y devuelva este formulario al empleado)

15. Para el plan más barato que satisface el estándar del valor mínimo* ofrecido **sólo al empleado** (no incluya planes familiares): Si el empleador tiene programas de bienestar, proporcione la prima que el empleado tendría que pagar si él/ ella recibiera el máximo descuento por cualesquiera programas para dejar de fumar, y si no recibiera ningún otro descuento basado en los programas de bienestar.

a. ¿Cuánto, en primas, tendría que pagar el empleado por este plan? \$ _____

b. ¿Con qué frecuencia? Semanal Cada 2 semanas 2 veces al mes Mensual Trimestral Anual

Si el año del plan va a terminar pronto y usted sabe que los planes de salud ofrecidos van a cambiar, vaya a la pregunta 16. Si no sabe, PARE y devuelva este formulario al empleado.

16. ¿Qué cambio hará el empleador para el nuevo año del plan?

El empleador no ofrecerá cobertura de salud

El empleador comenzará a ofrecer una cobertura de salud a los empleados o a cambiar las primas para el plan más barato disponible, solamente para el empleado, que satisfaga el estándar del valor mínimo.* (La prima debe reflejar el descuento por los programas de bienestar. Vea la pregunta 15.)

a. ¿Cuánto, en primas, tendrá que pagar el empleado por ese plan? \$ _____

b. ¿Con qué frecuencia? Semanal Cada 2 semanas 2 veces al mes Mensual Trimestral Anual

Fecha del cambio (mm/dd/aaaa): _____

* Un plan de salud patrocinado por el empleador satisface el "estándar del valor mínimo" si la porción del plan, del costo total del beneficio cubierto por el plan, es no menos del 60% de dichos costos (Sección 36B(c)(2)(C)(ii) del Código de Recaudación Interna de 1986)



¿NECESITA AYUDA CON SU SOLICITUD? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en Español, llame al 1-877-423-4746. Si necesita ayuda en otro idioma que no sea el Inglés, llame al 1-877-423-4746 y dígame al representante del servicio al cliente qué idioma necesita. Nosotros le conseguiremos ayuda gratis. Los usuarios de TTY deben llamar al 1-800-255-0135. Form 94a Appendix A (1/14)

ANEXO B

Familiar de Indio Americano o Nativo de Alaska (AI/AN)

Complete este anexo si usted o un familiar suyo son Indios Americanos o nativos de Alaska. Presente esto junto con su Solicitud de Cobertura de Salud y Ayuda para Pagar Costos.

Cuéntenos sobre su familiar, o familiares, que son Indios Americanos o Nativos de Alaska.

Los Indios Americanos y los Nativos de Alaska pueden obtener servicios de parte de los Servicios de Salud para Indios, de programas de salud tribal, o de programas de salud para indios urbanos. También es posible que no tengan que pagar costos compartidos, y puede ser que obtengan especiales períodos mensuales de inscripción. Conteste las siguientes preguntas para asegurar que su familia obtenga la mayor ayuda posible.

NOTA: Si tiene que incluir más personas, haga una copia de esta página y adjúntela.

	AI/AN PERSONA 1	AI/AN PERSONA 2
1. Nombre (Nombre de pila, Nombre del medio, Apellido)	Nombre de pila Nombre del medio Apellido	Nombre de pila Nombre del medio Apellido
2. ¿Miembro de una tribu reconocida por el gobierno federal?	<input type="checkbox"/> Sí Si la respuesta es sí, nombre de la tribu _____ <input type="checkbox"/> <input type="checkbox"/> No	<input type="checkbox"/> Sí Si la respuesta es sí, nombre de la tribu _____ <input type="checkbox"/> No <input type="checkbox"/>
3. ¿Esta persona alguna vez ha obtenido un servicio de parte del Servicio de Salud para Indios, de un programa de salud tribal, o de un programa de salud para indios urbanos, o a través de una derivación proveniente de uno de estos programas?	<input type="checkbox"/> Sí No Si la respuesta es no, ¿Esta persona es elegible para obtener servicios de parte del Servicio de Salud para Indios, de un programa de salud tribal, o de un programa de salud para indios urbanos, o a través de una derivación proveniente de uno de estos programas?	<input type="checkbox"/> Sí No Si la respuesta es no, ¿Esta persona es elegible para obtener servicios de parte del Servicio de Salud para Indios, de un programa de salud tribal, o de un programa de salud para indios urbanos, o a través de una derivación proveniente de uno de estos programas?
4. Algunos tipos de dinero recibido no pueden ser contados para el Medicaid ni para el Programa de Seguro de Salud de Niños (CHIP, por sus siglas en inglés). Liste cualquier ingreso (cantidad y frecuencia) reportado en su solicitud que incluya dinero de las siguientes fuentes: <ul style="list-style-type: none"> • Pagos per cápita de una tribu que vienen de recursos naturales, uso de derechos, arrendamientos, o regalías • Pagos por recursos naturales, agricultura, ganadería, pesca, arrendamientos, o regalías de tierra designada como tierra indígena en fideicomiso por el Departamento del Interior (incluyendo reservaciones y ex-reservaciones) • Dinero de la venta de cosas que tienen un significado cultural 	\$ _____ ¿Con qué frecuencia? _____	\$ _____ ¿Con qué frecuencia? _____



¿NECESITA AYUDA CON SU SOLICITUD? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en Español, llame al 1-877-423-4746. Si necesita ayuda en otro idioma que no sea el inglés, llame al 1-877-423-4746 y dígame al representante del servicio al cliente qué idioma necesita. Nosotros le conseguiremos ayuda gratis. Los usuarios de TTY deben llamar al 1-800-255-0135.

Form 94a Appendix B (1/14)

ANEXO C



DEPARTAMENTO DE SERVICIOS HUMANOS DE GEORGIA
División de Servicios para Familias y Niños



GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Form Approved
OMB No. 0938-1191

Ayuda para completar esta solicitud

Usted puede escoger a un representante autorizado.

Usted le puede dar permiso a una persona de confianza para que hable con nosotros sobre esta solicitud, para que vea su información y para que actúe como su representante en lo relacionado con esta solicitud, incluso para que obtenga información sobre su solicitud y para que firme su solicitud en su nombre.

A esta persona se le llama un "representante autorizado." Si alguna vez usted necesita cambiar su representante autorizado, llame a la División de Servicios para Familias y Niños (DFCS, por sus siglas en inglés) al 1-877-423-4746. Si usted es un representante, nombrado legalmente, de alguien que aparece en esta solicitud, presente una prueba junto con la solicitud.

1. Nombre del representante autorizado (Nombre de pila, Nombre del medio, Apellido)		
2. Dirección		3. Departamento o número de suite
4. Ciudad	5. Estado	6. Código postal
7. Número de teléfono () -		
8. Nombre de la organización		9. Número de identidad (si aplica)
Al firmar, usted está permitiendo que esta persona firme su solicitud, que obtenga información oficial sobre esta solicitud y que le represente en todos los asuntos futuros con esta agencia.		
10. Su firma		11. Fecha (mm/dd/aaaa)

Únicamente para consejeros, navegadores, representantes e intermediarios certificados.

Complete esta sección si usted es un consejero, navegador, representante o intermediario certificado que está llenando esta solicitud a nombre de alguna otra persona.

1. Fecha de comienzo de la solicitud (mm/dd/aaaa)	
2. Nombre de pila, nombre del medio, apellido, y sufijo	
3. Nombre de la organización	4. Número de identificación (si aplica)

¿NECESITA AYUDA CON SU SOLICITUD? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en Español, llame al 1-877-423-4746. Si necesita ayuda en otro idioma que no sea el inglés, llame al 1-877-423-4746 y dígame al representante del servicio al cliente qué idioma necesita. Nosotros le conseguiremos ayuda gratis. Los usuarios de TTY deben llamar al 1-800-255-0135.
Form 94a Appendix C (1/14)

NOTICE OF ACTION Form DMA 634:

634 Approval

This form is used to provide notice to the applicant when a PE determination is approved and the temporary Medicaid certificate was not printed. It is to be given to the beneficiary at the time of her PE approval. A copy of this form will be included in the PE packet given to RSM/DFCS.

634 Denial

This form is used to provide notice to the applicant when a PE determination is denied. It is to be given to the applicant at the time she is determined not eligible. A copy of this form will be included in the PE packet given to RSM/DFCS.

COMPLETION OF INDIVIDUAL ITEMS:

Complete the top part of the form showing identifying information:

Check the block if the applicant is not eligible and add reason she is not eligible. The reason for denial will be one or more of the reasons below:

- 1) The applicant is not a U.S. citizen or qualified immigrant.
- 2) The applicant is not pregnant per her statement.
- 3) The applicant's net taxable income is above 220% of the federal poverty level limit.
- 4) The applicant is not a GA resident.
- 5) Unable to determine, applicant refuses to verbally give tax status information.

Enter whichever reason is correct.

If found ineligible, this is the only form the applicant receives.

The person completing the Presumptive Eligibility determination will sign the form.



NOTICE OF ACTION

Presumptive Eligibility Pregnant Women Medicaid

[Redacted] Date

Name [Redacted]

Address [Redacted]

City [Redacted] State GA Zip Code [Redacted]

A. PRESUMPTIVE ELIGIBILITY APPROVED: [Redacted] Medicaid ID Number

Your application for Presumptive Eligibility (PE) Pregnant Women Medicaid is approved.

When you applied for PE Pregnant Women Medicaid, you may also have applied for Healthcare coverage. The Healthcare coverage application will be sent to the Division of Family and Children Services (DFCS) office or the Right from the Start Medicaid (RSM) Project. DFCS or RSM will make the decision for your full Medicaid benefits and notify you by mail.

This PE Medicaid coverage is limited to ambulatory prenatal care and does not provide coverage for inpatient hospital and delivery services. You must be approved for full Medicaid benefits in order for the costs of inpatient hospital and delivery services to be covered by the Medicaid program.

Your PE Medicaid coverage ends when a final determination of eligibility is made by the DFCS office or the RSM Project, or no later than the last day of the following month of your PE application.

Signature of Qualified Provider [Redacted] Qualified Provider Address [Redacted]

[Redacted] Title [Redacted] Phone Number [Redacted] Qualified Provider ID [Redacted]

DMA 634 Approval (Revised 4/1/14)



NOTICE OF ACTION

Presumptive Eligibility Pregnant Women Medicaid

Name [redacted] Date [redacted]
Address [redacted]
City [redacted] State GA Zip Code [redacted]

B. PRESUMPTIVE ELIGIBILITY DENIED:

Your application for Presumptive Eligibility (PE) Pregnant Women Medicaid is denied.

The reason for denial is: Not a Qualified Immigrant

When you applied for PE Pregnant Women Medicaid, you may also have applied for Healthcare coverage. Your Healthcare coverage application has been sent to the Division of Family and Children Services (DFCS) office or the Right from the Start Medicaid (RSM) Project for a final determination of eligibility. DFCS or RSM may determine you are potentially eligible for another type of Medicaid and will notify you. If you are not eligible for Medicaid your Healthcare coverage application will be referred to the Federally Facilitated Marketplace (FFM) for consideration. You will be notified directly by the FFM.

You may find additional FFM information, or apply directly for Healthcare coverage at www.healthcare.gov, or you may call the FFM any time at 1-800-318-2596, TTY 1-855-889-4325.

Signature of Qualified Provider [redacted] Qualified Provider Address [redacted]
Title [redacted] Phone Number [redacted] Qualified Provider ID [redacted]

DMA 634 Denial (Revised 3/1/14)

Declaration of Citizenship/Immigration Status:

This form is completed by the applicant to self-declare citizenship/qualified immigration status.

It must be given to all applicants who apply for PE Medicaid.

A copy should be retained in the case file and a copy sent to the RSM/DFCS office as part of the PE Packet.

It is not required when the **Health Coverage** application Form 94A has been completed and signed by the applicant or if page 3 of the Medicaid application Form 94 is completed because both forms include this information.

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the United States Department of Homeland Security (DHS) of my/my children's citizenship or immigration status when seeking benefits. Information received from DHS may affect my/my children's eligibility.

Please fill out and sign **ONE** or **BOTH** of the following statements as it pertains to the status of each person seeking benefits.

CHILDREN SEEKING BENEFITS

Name	Place of Birth (city, state, country)	U.S. Citizen (check whichever applies)	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID# (If applicable)
					A-

I, _____
(PRINT NAME) attest to the identity of the child/children listed above and certify under penalty of perjury, that the information written and checked above is true.

SIGNATURE (PARENT GUARDIAN)

(DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth (city, State, Country)	U.S. Citizen (check whichever applies)	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID# (If applicable)
					A-
					A-

I, _____
(PRINT NAME) certify under penalty of perjury, that the information written and checked above is true.

SIGNATURE

(DATE)

SIGNATURE

(DATE)

DECLARACIÓN DE LA CIUDADANÍA/ESTATUS DE EXTRANJERO

Departamento de Servicios Humanos de Georgia
 Departamento de Servicios para las Familias y los Niños

Yo entiendo que la División de Servicios para las Familias y los Niños de Georgia (DFCS) puede requerir verificación del Departamento de Seguridad Nacional de los Estados Unidos (*Department of Homeland Security* o *DHS*) de mi ciudadanía o la ciudadanía de mis niños o estado de extranjero al buscar beneficios. La información recibida de *DHS* puede afectar mi elegibilidad o la elegibilidad de mis niños.

Por favor, complete y firme UNA o AMBAS de las siguientes afirmaciones, según sean pertinentes a la situación de cada persona que busca beneficios.

NIÑOS QUE BUSCAN BENEFICIOS

Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano	Inmigrante	Fecha de	Numero del
		de los E.E.U.U.	Admitido Legalmente	Naturalización o Admisión a los E.E.U.U.	Documento de Identidad
		(Marque el que aplique)		(Si es aplicable)	(Si es aplicable)
					A-

Yo, _____ atestigo la identidad del (de los) niño(s) enlistado(s) arriba y
(NOMBRE EN LETRA DE MOLDE O IMPRENTA)
 certifico bajo penalidad de perjurio que la información escrita y marcada arriba es cierta.

 FIRMA (PADRE/MADRE/GUARDIAN)

 (FECHA)

ADULTO(S) QUE BUSCA(N) BENEFICIOS

Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano	Inmigrante	Fecha de	Numero del
		de los E.E.U.U.	Admitido Legalmente	Naturalización o Admisión a los E.E.U.U.	Documento de Identidad
		(Marque el que aplique)		(Si es aplicable)	(Si es aplicable)
					A-
					A-

Yo, _____ certifico bajo la penalidad del perjurio, que la información
(NOMBRE EN LETRA DE MOLDE O IMPRENTA)
 escrita y marcada arriba es cierta.

 FIRMA

 (FECHA)

 FIRMA

 (FECHA)

Notice of Privacy Practices form 5460:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The [Privacy Ruling](#) was published in the Federal Register on December 28, 2000. The U.S. Department of Health and Human Services' Office for Civil Rights is responsible for enforcing this rule. There are civil and criminal penalties for violating this rule, including fines up to \$250,000 and imprisonment for up to 10 years.

The privacy regulation has three major purposes:

- To protect and enhance the rights of consumers by providing them access to their health information and controlling the appropriate use of that information;
- To improve the quality of health care in the United States by restoring trust in the health care system among consumers, health care professionals and the many organizations and individuals committed to the delivery of health care; and
- To improve the efficiency and effectiveness of health care delivery by creating a national framework for health, privacy and protection.

Each time an application is submitted for PE a new HIPAA form 5460 will be given to the applicant to be completed regardless if the PE application is approved or denied. Since all PE applications will go to the local RSM outreach worker, the HIPAA form 5460 from the Department of Human Service (DHS) is being used. This is a front and back form that is available in English or Spanish. QP/QH will have to add the HIPAA contact information in section 3 to match that of their local DFCS county information. The applicant receives a copy of this notice.

3. Complaints related to use or disclosure of your protected health information

You may complain to the Department and to the Secretary of Health and Human Services **if you believe your health information privacy rights have been violated**. You may file a complaint in writing with the DHS Division, Office or Facility which maintains your PHI at telephone (____) **DFCS** - **PHONE** , facsimile (____) **DFCS** - **FAX** , or by mail to:

ADD DFCS INFORMATION HERE

Please sign a copy of this Notice of Privacy Practices for the Department's records.

I have received a copy of this Notice on the date indicated below:

APPLICANT'S SIGNATURE HERE

APPLICANT'S MAILING ADDRESS HERE

Signature

Mailing Address

APPLICANT'S PRINTED NAME

(Please print name)

Date

City, State, Zip

After you sign and date please mail or bring the original to:

QP'S /QH'S COUNTY HERE

QP'S /QH'S NAME HERE

N/A

County Office

Case Manager

Load #

QP'S /QH'S MAILING ADDRESS HERE

Mailing Address

City, State, Zip

If you are using the new version of the HIPAA form below only the last page, signature/date, needs to be included in the PE Packet.

Revised
04/01/14

HIPAA Notice of Privacy Practices Georgia Department of Human Services

Effective Date: August 15, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact:

Georgia Department of Human Services
HIPAA Privacy Officer
HIPAA1@dhr.state.ga.us
(404) 657-9761 phone
(404) 657-1123 fax

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this Notice.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways DHS may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, DHS will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to the HIPAA Privacy Officer at the contact information above.

For Treatment. DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the

treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

For Health Care Operations. DHS may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that quality care is received and to operate, manage, and administer the functions of the agency. For example, DHS may use and disclose information to make sure the medical care you receive is of the highest quality. DHS also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. DHS may use and disclose Health Information to contact you to remind you of an appointment with a physician. DHS also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, DHS may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. DHS will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. DHS may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform billing services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, DHS may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information DHS has is incorrect or incomplete, you may request DHS to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures DHS made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid "out-of-pocket" in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the above-referenced HIPAA

Privacy Officer. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the above-referenced HIPAA Privacy Officer.

CHANGES TO THIS NOTICE:

DHS reserves the right to change this notice and make the new notice apply to Health Information already obtained as well as any information received in the future. DHS will post a copy of the current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint, in writing, by contacting the above-referenced HIPAA Privacy Officer. **You will not be penalized for filing a complaint.**

You may also file with the Secretary of the Department of Health and Human Services. For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

I have read, understand, and acknowledge receipt of the DHS HIPAA Notice of Privacy Practices.

Signature

Date

Print Name

**INSTRUCTIONS FOR COMPLETION OF THE GEORGIA DEPARTMENT OF
COMMUNITY HEALTH THIRD PARTY LIABILITY HEALTH
INSURANCE INFORMATION QUESTIONNAIRE FORM DMA 285**

§433.145 Assignment of rights to benefits—State plan requirements./SPA ATTACHMENT 2.6-A Page 3a

PURPOSE

The purpose of this form is to provide the Department of Community Health (DCH) with information regarding the availability of third party liability (TPL) to beneficiaries and to report to DCH any subsequent changes to such TPL. It is also used to document that the beneficiary agrees to assign their rights to payments from TPL to DCH.

TPL available to the beneficiary must be used by DCH to reduce or recover Medicaid payments for medical services. Resources include group, private, or HMO health insurance policies held by the beneficiary, beneficiary's parent, absent parent or divorced parent; federal and state health insurance programs; casualty and liability insurance including automobile or school coverage for an accident; business insurance for an injury on business premises; or homeowner's insurance for an injury on owner's premises. TPL do not include life insurance policies, mortgage insurance, or any supplemental income policies. Do not complete a DMA 285 for Medicare.

PREPARATION

The original copy of newly completed DMA 285's, as well as copies reporting additions, changes, or cancellations are to be mailed to:

Health Management System (HMS)
900 Circle 75 Parkway
Suite 650
Atlanta, GA 30339
OR
Fax: 770-937-0180

The DMA 285 Form should be prepared, dated, and signed by the caseworker and applicant at the initial interview. When reporting information on a TPL, send the completed first page to HMS and retain the two remaining copies in the beneficiary's file. A separate DMA 285 should be prepared and sent for each insurance carrier.

The DMA 285 form can be screen printed from Appendix F or from the GAMMIS website form section. When reporting TPR send the original completed screened printed form to HMS, and keep a photo copy in the file.

If no TPL are reported, do not complete a form DMA 285 if application form DMA 632W with revision date 01/1/13 was used. If an earlier version was used then have the applicant complete the DMA 285 indicating no TPL exist. A new form should be completed when TPL are added or if there is a change in employer related group coverage. Mark "Change" box and show the new information in the appropriate section. If a previously TPL is no longer valid, i.e., is dropped or cancelled, use one of the retained copies of the form and check the "cancellation" block, record the effective date of the cancellation on the line labeled "Policy Termination Date" and send to HMS.

EXAMPLE OF FORM DMA 285 COMPLETED:

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH – THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE**

CASE NAME: Applicant's Name CASE NO: N/A (for PE)
 ADDRESS: Applicant's mailing SSN: 123-45-6789
Address PHONE NO: Day time phone number

TYPE OF CASE: INITIAL APPLICATION SPECIAL NEEDS TRUST (SNT) CHANGE CANCELLATION
 (Check all that apply) HIPPA REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION: 01 /01 /XX

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25); 42 CFR 433.125-139). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

Do you have a private, group or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Is policyholder an Adult Parent? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
Does your spouse, parent or stepparent have any private, group or government health insurance that pays any of the cost of your medical care? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	

Names of Covered Individuals in Household (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	
Member Georgia	111223456789	123-45-6789					X	2/11/70

Are any of these persons pregnant? YES NO If yes, Name Georgia Member Date of Delivery 5/22/xx

ATTACH A COPY OF INSURANCE CARD/POLICY AND A COPY OF SNT	Do any of the persons listed above have a chronic medical condition? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, Name _____ Condition _____
--	---

BCBS (800) 331-BCBS
 (Insurance Company Name) (Telephone Number)

2 Peachtree Street Columbus GA 33392
 (Address) (City) (State) (Zip)

Mr. X Husband Member 987-65-4321 ABC123 04/19/65
 (Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

12/31/00
 (Policy Effective Date)

ABC Construction 706-321-5555
 (Employer Name) (Telephone Number)

211 Maple Drive LaGrange GA 34567
 (Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)	
01 - HOSPITAL INPT.	15 - LTCNH
07 - DRUG/STND	16 - HMO/DRUG
08 - MAJOR MED.	17 - MED. SUPP A
09 - DENTAL	18 - MED. SUPP B
10 - VISION	22 - HMO/STND
OTHER _____	

I authorize the release of information necessary to identify health/liability insurance benefits to the Department of Community Health. I also certify that the above information is correct.

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.

Signed Applicant's Signature Date 01/01/xx Signed Applicant's Signature Date 01/01/xx
 Member or Authorized Person Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY 01/01/xx

Case Worker Name: Qualified Provider Worker Phone No. Direct Phone County _____

DMA-285-32IV. (01/05)

The only items that are required to be completed after a PE Pregnant Women Medicaid approval, that has TPL, are the top part of the form and the two applicant's signatures and date.

Quick Guide on Medicaid for Pregnant Women-Fact Sheet

This document is for informational purposes, only. For applicants, who apply for PE with QP/QH, it explains to them Pregnancy Medicaid and what to expect if their application is approved for the program.

To assist the applicant in keeping abreast of the status of her Medicaid application, this document contains an entry for the telephone number of the local county Division of Family and Children Services (DFCS) or Right from the Start Medicaid (RSM) Project office. QP/QH should supply this number and give the temporary Medicaid Certification (approvals) to the applicant, along with other forms she receives, as part of the application process.



Quick Guide on Medicaid for Pregnant Women

If you applied for healthcare coverage, your application is being sent to your local county Division of Family and Children Services (DFCS) office or Right from the Start Medicaid (RSM) office to finish processing.

You will be assigned a caseworker you can reach by calling _____. This caseworker may call you for additional information. Contact the DFCS Call Center at 1-877-423-4746 (TDD/TTY 1-800-255-0135) if you move, especially to another county or out of state. (You cannot receive Georgia Medicaid if you do not live in Georgia). You may also fax your changes/verification to the DFCS Call Center Fax at 1-888-740-9355 or through www.compass.ga.gov. You must report to DFCS in 10 days if you are no longer pregnant

You will receive a letter in the mail letting you know whether or not your healthcare coverage application is approved. If approved, Medicaid will cover you as long as you are pregnant and for 60 days after you deliver your baby. There are other types of Medicaid that may cover you after this point, you can ask DFCS.

As soon as you are eligible for Medicaid, you will be mailed an enrollment packet from Georgia Families. Once you get your packet, you can mail or fax your CMO choice in quickly. You don't have to wait until your packet arrives to enroll in Georgia Families as you can also enroll by phone (1-888-GA-ENROL) or by internet at: <http://www.georgia-families.com>. You should receive an enrollment packet within 20 days from today. If you do not receive your packet please call 1-888-423-6765.

Following approval and beginning in your 8th month of pregnancy, you will receive a form from the DFCS office asking if you are still pregnant or have had your baby. You must fill out this form and return it.

Before you leave the hospital, you should get a **temporary** Medicaid card to cover your baby until the plastic one comes in the mail. After you have your baby, contact the DFCS Call Center at 1-877-423-4746 (TDD/TTY 1-800-255-0135) to report the baby's name and birth date. You may also fax your newborn's information to the DFCS Call Center Fax at 1-888-740-9355 or report the birth through www.compass.ga.gov. Once you report this information your baby will receive Medicaid for their first year called Newborn Medicaid. There are no renewals during this first year under Deemed Newborn Medicaid. Once your baby turns a year old DFCS will do a review to determine if your baby still qualifies for Medicaid or if a PeachCare for Kids® referral is needed.

If you need a replacement Medicaid card call the Member Contact Center at 1-866-211-0950.

Medicaid covers prenatal care and delivery and most medical services and items; there are no co-pays for pregnant members. If you have questions about what else Medicaid covers, ask your doctor or call: 1-866-211-0950.

Revised 4/1/2014

PUT ON OFFICE LETTERHEAD

PRESUMPTIVE ELIGIBILITY CHANGES/CORRECTIONS

**FAX TO: HP Member Enrollment
1-866-483-1045**

TODAY'S DATE: _____

UPDATE (check one):

PE PREGNANCY
Attach Form 632

PE WHM
Attach Form 632W

Name

Address

Residential County Code

Social Security Number

Date of Birth

Duplicate ID Merge: _____ **Original** _____ **Duplicate**

Application Date (only if the application date is in another month)

IN ADDITION TO THE ABOVE CHANGE(S) THE ITEMS BELOW ALSO NEED CORRECTED:

Note: If any of the items below are the only correction(s) needed do not fax this form to HP. The information will be updated in GAMMIS when the full Medicaid application is completed.

Administrative County Code

Race: American Indian or Alaskan Asian Black Caucasian

Hispanic Other: _____ (specify)

Ethnicity: Hispanic N/A

Citizenship: U.S. Citizen Qualified Immigrant Illegal Immigrant

Other: _____ (specify)

Expected Birth Date of Fetus

Number of Births

CONTACT INFORMATION:

Name of person completing this form: _____
Please Print Clearly

Direct phone number of person completing this form: _____

CONFIDENTIALITY PROVISION

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee of agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original, message to us at the above address via the U.S. Postal Service. Thank you.

Revised 3/1/12

**Supplemental Security Income (SSI) Pregnant
Women Update**

FAX TO: HP Member Enrollment
1-866-483-1045

TODAY'S DATE: _____

Beneficiary's Name: _____

Beneficiary's Member ID Number: _____

Number of Weeks Pregnant: _____

Expected Birth Date of Fetus: _____

Number of Expected Fetus(es): _____

CONTACT INFORMATION:

Name of person completing this coversheet: _____
Please Print Clearly

Provider Name: _____
Please Print Clearly

Provider ID Number: _____
Please Print Clearly

Direct phone number of person completing this coversheet: _____
Please Print Clearly

CONFIDENTIALITY PROVISION

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee of agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original, message to us at the above address via the U.S. Postal Service. Thank you.

04/1/2014

APPENDIX G - GAMMIS

Sign on to GAMMIS:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

For assistance please contact the [HP Helpdesk](#)

Sign in to the Georgia Medicaid

- Access your applications
- Manage your account
- Change your password
- Submit Authorizations

If you are the Office Administrator authorized by the Provider, register [here](#).

Sign in to Georgia Medicaid [Help](#)

Username:

Password:

Sign In

Georgia Medicaid
Forgot your password?

User Name (points to Username field)

Password (points to Password field)

Get Password (points to Forgot your password? link)

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

For assistance please contact the [HP Helpdesk](#)

Georgia Medicaid Home [Sign Out](#)

Public Health Welcome to Georgia Medicaid

Applications

Application	Description
MEUPS Account Management Web Portal	Manages contact information, password, and authorizations for applications. Web Portal Production

Messages
There are no new messages.

To Access the Web Go Here (points to MEUPS Account Management Web Portal link)

To Change Your Password and Personal Information Go Here. It Takes You Here. (points to MEUPS Account Management Web Portal link)

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

For assistance please contact the [HP Helpdesk](#)

Account Home [Close Application](#)

[Account Home](#) [My Information](#) [Change Password](#) [Reports](#)

Account Home

Good Morning Public Health

Please select a button above to view or edit your account.

Password Last Modified: 10/26/2010 11:24:37 AM
Your password will expire in 11 days.

Passwords Expire in 60 Days. This Screen Tells You the Days Remaining. (points to password expiration notice)

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Going to the Web:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH | **GEORGIA WEB PORTAL** | **GEORGIA HEALTH PARTNERSHIP**

[Refresh session] You have approximately 19 minutes until your session will expire. Tuesday, December 14, 2010

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Home Publication Search Site Map Site Settings Language Selection

(click to hide) Alert Message posted 12/9/2010

Trading Partner PIN Activation
 All Trading Partners (those who submit EDI batch files to Georgia Medicaid) will be receiving a Trading Partner Personal Identification Number (PIN) letter.
 If you are a trading partner and you have not received your letter by Sunday, October 24, 2010, then you should contact EDI Services at (770) 325-9590 or toll-free at (877) 261-8785.
 Those trading partners who have their PIN letter should [click here to register at our Trading Partner PIN Activation page.](#)

Attention Payees Receiving ERAs.
Important: Provider's enrolled for Electronic Remittance Advices (ERA's) must activate their Payee Provider Web Portal PIN's that they received in the mail.
 ERA's are generated using the PAYEE Provider ID; therefore, if you wish to delegate these 835 ERA's so that your clearinghouse/software vendor/billing

(click to hide) Alert Message posted 10/28/2010

Switch User or Switch Trading Partner panel
 To begin acting as a particular provider or trading partner, use the Switch Provider or Switch Trading Partner panel below.
 Once a selection has been made and confirmed, additional menu items will be displayed based on the roles delegated to you.

User Information - Agent PHALLEN

Switch Provider

National Provider ID: Address:
 Medicaid Provider ID: City:
 Name: Zip:

If you have more than one choice choose your office.

(2 rows returned)

National Provider ID	Medicaid Provider ID	id	Provider Type	Name	Address	City	State	Zip	Zip + 4
		26G	Public Health A						
		29N	Public Health A						

Select row above to switch to the desired provider.

Messages:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH | **GEORGIA WEB PORTAL** | **GEORGIA HEALTH PARTNERSHIP**

Welcome Public Health [Search]

[Refresh session] You have approximately 19 minutes until your session will expire. Tuesday, December 14, 2010

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Account | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization

Home Messages Switch Eligibility Eligibility

User Information - Provider 000457729N

Messages

Category	Subject	Sent Date	Effective Date	End Date	Remove
PROVIDER ALERT	Suspended Claim Attachments	12/01/2010	12/01/2010	12/31/2010	<input type="checkbox"/>
PROVIDER ALERT	EOB / Adjustment Reason / Remark Codes Crosswalk	12/01/2010	12/01/2010	12/20/2010	<input type="checkbox"/>
PROVIDER ALERT	5010 Workshops	11/22/2010	11/15/2010	12/20/2010	<input type="checkbox"/>
NOTIFICATION	Electronic Claims Require Identifying Service Loca	11/15/2010	11/12/2010	12/15/2010	<input type="checkbox"/>

Select All Save Deselect All

Screening on the web portal:

Always screen on the web first to make sure the applicant is not already active on Medicaid.

The screenshot shows the Georgia Department of Community Health Web Portal. The header includes the Georgia Department of Community Health logo, the text "GEORGIA WEB PORTAL", and the Georgia Health Partnership logo. A blue banner reads "Welcome Public Health" with a search button. Below the banner, a session timer indicates "Tuesday, December 14, 2010" and a message: "[Refresh session] You have approximately 19 minutes until your session will expire." A navigation menu includes: Home, Contact Information, Member Information, Provider Information, Provider Enrollment, Nurse Aide, EDI, Pharmacy, Account, Training, Claims, Eligibility, Presumptive Activations, Health Check, and Prior Authorization. The "Eligibility" menu item is selected, showing a dropdown with options: Home, Eligibility Request, Newborn Activations, Pregnant Women Activations, and Women's Health Activations. The "Eligibility Request" option is highlighted. Below the navigation is a "User Information - Provider 0004577" section with a help icon. A note states: "Note: If a member is enrolled in a managed care plan on the date of admission, the plan is responsible for the entire stay as long as Medicaid eligibility is maintained. If the member is enrolled in a fee for service program on the date of admission, then the fee for service program is responsible for the entire hospital stay as long as Medicaid eligibility is maintained." The main form is titled "Eligibility Verification Request" and contains the following fields: Member ID, Last Name, First Name, Gender, Birth Date, SSN, and From/Thru Date of Service. There are search and clear buttons at the bottom right of the form.

If the applicant was ever known to the system, you will see her as inactive at the bottom of the screen.

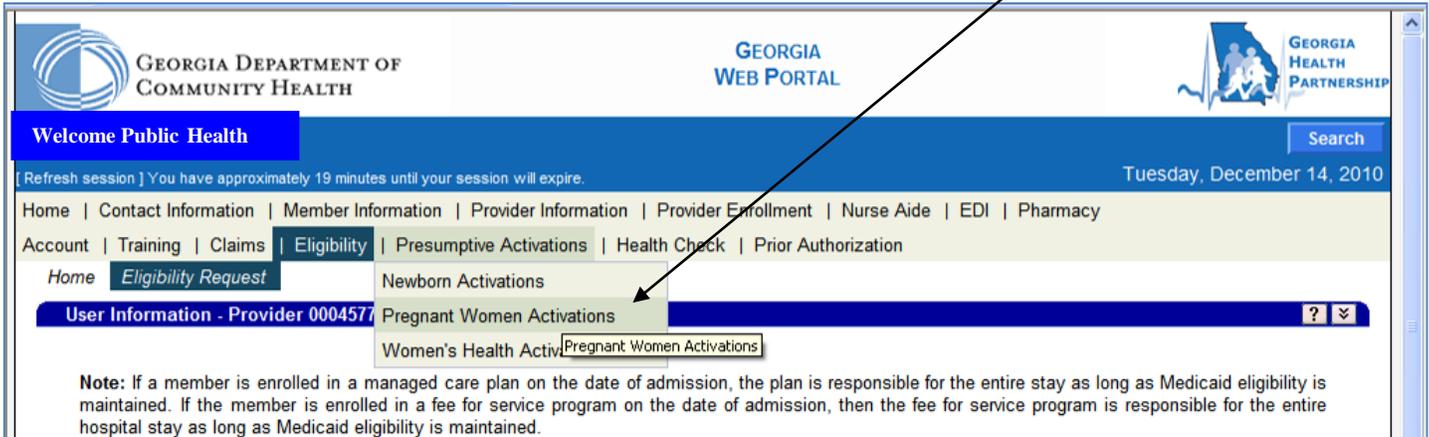
The screenshot shows the "Eligibility Verification Request" form filled out with the following data: Member ID: 11122233444, Birth Date: [empty], Last Name: [empty], SSN: [empty], First Name: [empty], From/Thru Date of Service: 09/30/20XX to 10/24/20XX, Gender: [empty]. There are search and clear buttons. Below the form is the "Member ID Information" section, which displays the following details: Member ID: 11122233444, Birth Date: 12/4/19XX, Address 1: 123 ABC STREET, Address 2(County): 107 - NEWTON, City: COVINGTON, State: GA, Zip: 30016-2907, First Name: L., Last Name: SMITH, Middle Initial: H., Name Suffix: [empty], Gender: F, Transaction Date/Time: 10/03/20 02:54:59, Confirmation #: 122770010D. A blue callout box with an arrow pointing to the Member ID field contains the text: "Her original Medicaid Number will appear here." Below this is the "Eligibility Spans" section, which is a table with the following data:

Status	Service Type Code	Insurance Type Code	Aid Category	Effective Date	End Date	Special Notes or Limitations
Inactive				09/30/20	10/24/20	

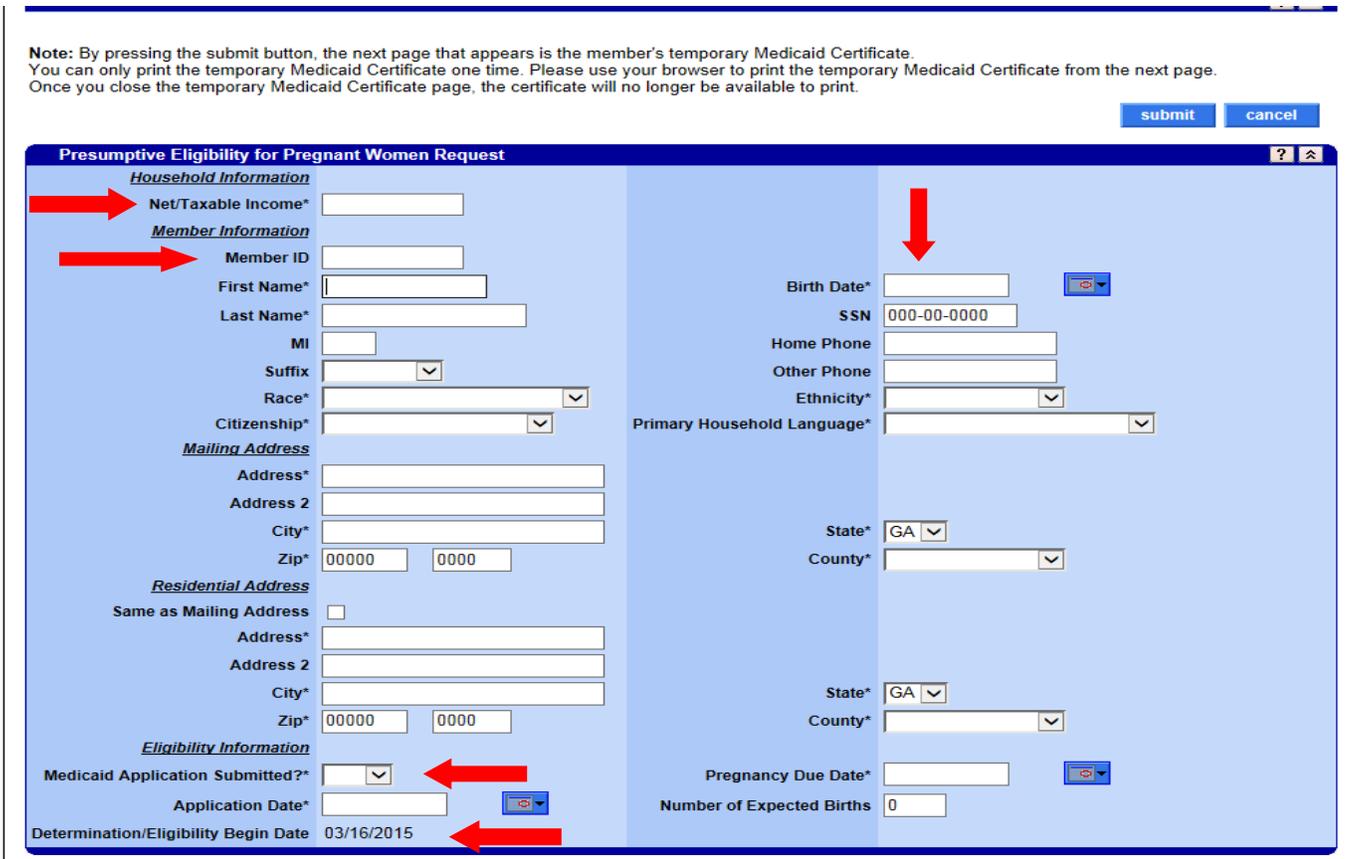
An arrow points to the "Inactive" status in the table.

If she has never had Medicaid this screen will not appear.

If your applicant does not have active Medicaid nor has ever been known to the system, you can process the PE application on line. Use the PE tab:

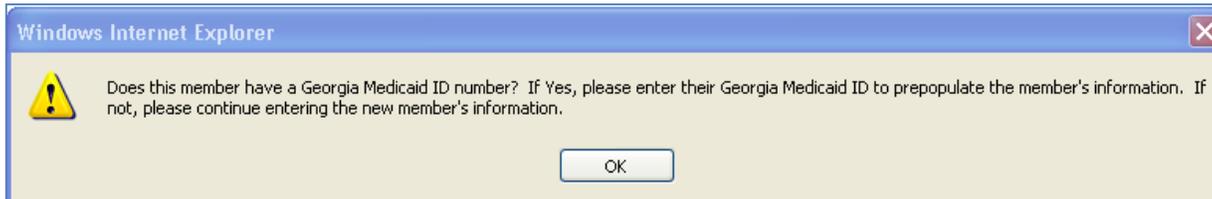


The PE Screen will appear:



Enter the applicant's original ID number to auto-populate the fields on this panel.

You will be prompted to do so with this alert message:



All information can be changed except the First Name, Date of Birth (DOB) and Social Security Number (SSN). If this information needs to be corrected use the current PE Corrections Coversheet procedure after you enter the PE in the Web.

Once you enter the Member ID number and the submit button you will receive this alert message:

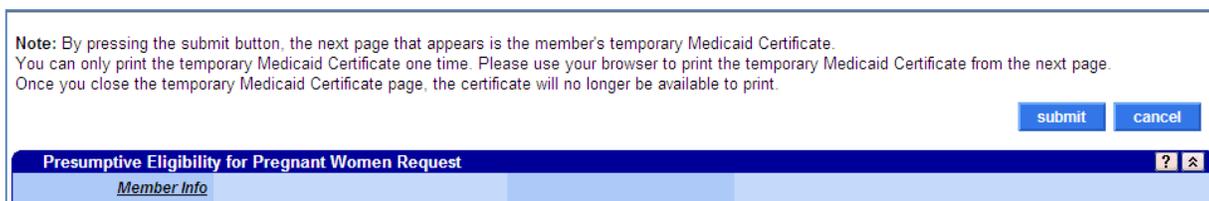


The applicant's last known information in GAMMIS will auto-populate. The Determination/Eligibility Begin Date field will pre-populate with today's date. This field cannot be modified.

Revised
04/01/15

<u>Eligibility Information</u>	
Medicaid Application Submitted?*	<input type="text" value="v"/>
Application Date*	<input type="text" value=""/>
Determination/Eligibility Begin Date	03/16/2015
Pregnancy Due Date*	<input type="text" value=""/>
Number of Expected Births	<input type="text" value="0"/>

Once all the information is entered on the PE Panel select the Submit button at the top of the screen to finalize the PE application on the Web.



The presumptive eligibility request was successfully processed message will appear:

The following messages were generated:
 The presumptive eligibility request was successfully processed. The Medicaid ID is 111222333444. Select the following link open a [certificate of eligibility](#), if a window does not appear or if you close the initial certificate

Presumptive Eligibility for Pregnant Women Request ?

[Member Info](#)

The Temporary Medicaid Certificate will appear in a separate box automatically. Print for the member.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

GEORGIA
WEB PORTAL



Welcome, Search

[Refresh session](#) | You have approximately 19 minutes until your session will expire. Wednesday, October 03, 20

Temporary Member Identification Card

Please note: Once the user navigates from this confirmation page, this information will no longer be accessible outside of performing an eligibility request on the member below. Therefore, please use your browser to print this confirmation page before closing.

Thank you for your participation in the Medicaid/PeachCare for Kids® program. Your presumptive eligibility entry has been received. The Member ID is listed below. This is the number you will need to use when submitting claims for services rendered to this member.

Please check the member eligibility site regularly for updates to this member's eligibility information. You may also access current eligibility information by clicking "Contact Us" under the Contact Information tab in the upper top left of your web screen; or by calling the Provider Contact Center at 1-800-766-4456; or by using the Interactive Voice Response (IVR) System at 1-800-766-4456.

This temporary member identification card may be used as a confirmation of presumptive eligibility for the Medicaid program as of the indicated date. A permanent identification card will be mailed to the member at the address below. Please print this page for the member to use until their member ID card arrives.

A Division of Family and Children Services Medicaid Eligibility Specialist will contact the member about her eligibility. Rx BIN Number 003858

Eligibility Verification Request ?

From/Thru Date of Service:

Member ID Information ?

Member ID Birth Date Address 1 Address 2(County) City State Zip	First Name Last Name Middle Initial Name Suffix Gender: F Transaction DateTime: 10/03/20 03:43:02 Confirmation #: 1227700132
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Eligibility Spans ?

Status	Service Type Code	Insurance Type Code	Aid Category	Effective Date	End Date	Special Notes or Limitations
Active	30-Health Benefit Plan Coverage	MC-Medicaid	865 - Presumptive Preg. Woman	09/01/20	10/31/20	THIS IS A PRESUMPTIVE ELIGIBLE MEMBER. INPATIENT HOSPITAL AND DELIVERY PROCEDURES ARE NOT COVERED

Appendix I - Income

Revised
7/1/16

2499 – TREATMENT OF INCOME IN MEDICAID

Use the chart below to determine the following treatment for a specific type of income:

- Whether the income is included (I) or excluded (E) in the Medicaid eligibility budgets for ABD and Family Medicaid and patient liability/cost share budgets
- Whether the income is earned or unearned
- Specific verification requirements, if any.

NOTE: If specific verification requirements are not listed, verify the income from the source.

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ACCIDENT OR HEALTH PLAN	Unearned- the value of accident or health plan coverage provided by an employer.	E(MAGI and Non MAGI)	
	Long Term Care Coverage- contributions by an employer to provide coverage for long-term services. This includes Archer MSA contributions.	E(MAGI and Non MAGI)	
	Health Flexible Spending Arrangement (health FSA)- employer provided health FSA which will result in a reduction of salary and reimbursements of medical care.	E(MAGI and Non MAGI)	
	Health Savings Accounts (HSA)- contributions made by the individual are deductions for tax returns.	E(MAGI and Non MAGI)	
	Distributions from HSA that are used to pay medical expenses.	E(MAGI and Non MAGI)	
	Distribution from HSA that are not used to pay medical expenses.	E(MAGI and Non MAGI)	
	Contributions to HSA made by employers	I(MAGI and Non MAGI)	
	Qualified HAS funding distribution-a onetime distribution from an individual retirement account (IRS) to an HAS.	E(MAGI and Non MAGI)	

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ADOPTION ASSISTANCE	Unearned – Payment received for the adoption of certain children.	E(MAGI and Non MAGI)	E
IV-E	Exclude as income.	E(MAGI and Non MAGI)	E
IV-B	Exclude as income.		
ADVANCE	Unearned – Money for future expenses that does not represent a gain to the AU. Earned – A prepayment of wages or salaries.	E(MAGI and Non MAGI) I(MAGI and Non MAGI)	E I
AGENT ORANGE PAYMENTS	Unearned – A payment made to a Vietnam Veteran who was exposed to Agent Orange defoliant. The payment is made to the surviving spouse and children.	E(MAGI and Non MAGI)	I
ALASKA NATIVE CLAIM	Unearned – Payments made under Alaska Native Claims Settlement Act. Alaska Permanent Fund Dividend-payment from Alaska’s mineral income fund.	E (MAGI and Non MAGI) I(MAGI and Non MAGI)	I I
ALIMONY/ SPOUSAL SUPPORT	Unearned – A court-ordered payment from an estranged spouse or former spouse to the other spouse for support under the terms of a court order or settlement agreement following a divorce. Payments may be in one lump sum, or in a series of monthly payments. Alimony is also termed “spousal support” or “maintenance”.	I(MAGI and Non MAGI)	I
AMERICORPS	Income from Americorps Network of programs which encompasses: Americorps USA Americorps VISTA Americorps NCCC Are handled as specified below:		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	Living Allowance Stipend – Earned Income	E (Non MAGI) I (MAGI)	E
	On-the Job Training – Earned Income	E (Non MAGI) I (MAGI)	E
ANNUITY	Unearned – Recurring payment received from an investment. Refer to Section 2339 , Trust Property, Annuities.	I(MAGI and Non MAGI)	I
ASSISTANCE BASED ON NEED (ABON)	Unearned – assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a state or local government.	E(MAGI and Non MAGI)	E
BLACK LUNG BENEFITS	Unearned – benefits paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act. Phone number for United Mine Workers is 1-800-654-9763.	I (Non MAGI) E (MAGI)	I
BLOOD, sale of	Earned – Money received from the sale of blood including blood products.	I(MAGI and Non MAGI)	I
BOARDER INCOME	Earned – Direct payments for food and related shelter expenses, less the cost of doing business.	I(MAGI and Non MAGI)	I
BONUS	Earned – Wages paid in addition to the usual or expected wages. Refer to Wages in this chart.	I (MAGI and Non MAGI)	I
CAPITAL GAINS	Earned or Unearned – profits from the sale of capital goods or equipment. Capital assets are resources such as stock, securities, real estate and equipment that are typically held as an investment for a period of time. A capital gain is realized when the item(s) sold have appreciated in value from the original purchase price.	I(MAGI and Non MAGI)	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CENSUS INCOME	Earned- All wages paid by the Census Bureau for temporary employment related to Census activities.	E (MAGI and Non MAGI)	E
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATION NOT STATE/ FEDERALLY FUNDED	Unearned – Charitable donation paid to the AU or BG.	E(MAGI and Non MAGI)	E
CHARITABLE DONATION FROM FEDERALLY OR STATE FUNDED ORGANIZATION	Unearned – Charitable donation paid to the AU or BG from organizations receiving state or federal funds. For example: Salvation Army, United Way, Catholic Charities, and Lutheran Social Service Agencies.	I(MAGI and Non MAGI)	I
CHILD CARE ATTENDANT (wages earned by)	<p>Earned – income received for providing child care services.</p> <p>Consider the income as follows:</p> <ul style="list-style-type: none"> • Self-employment if the attendant provides child care services in his/her home <p>As wages if the attendant provides services in the home of the child.</p>	I(MAGI and Non MAGI)	I
CHILD CARE PAYMENTS	Unearned – Payments made under Title IV of the Social Security Act to a child care provider on behalf of the AU. These payments include Transitional Child Care, and At Risk block grant child care payments made under P.L 101-508, Section 5801 of the Social Security Act.	E(MAGI and Non MAGI)	E
CHILD NUTRITION PAYMENTS	<p>Unearned – The value of meals provided to a child in day care through the Child Nutrition Amendment of 1978.</p> <p>* If the payment is for a child of the attendant, budget the entire amount as</p>	*I(MAGI and Non MAGI)	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<p>unearned income.</p> <p>If the payment is for any other child, treat as self-employment income.</p> <p>Refer to the Section 2415, Self Employment.</p>		
CHILD SUPPORT	<p>Unearned – Income received for the support of child (ren) from the non-custodial parent of the child. Child support paid for a child by a non-custodial parent is always income to the child and never to a parent/ relative/ guardian.</p> <p>*If an ABD Medicaid child (including LA-D A/Rs) receives child support from a non-custodial parent exclude from the eligibility budget 1/3 of the monthly child support received.</p>	<p>I (ABD) E (MAGI) I (Non MAGI)</p>	I
CHILD'S EARNINGS Children in Placement	<p>Earned – Income earned by a child, including MAGI Medicaid under 19 years old and for CW-FC children to 21 years.</p> <p>*Refer to Section 2610 to determine when Child's Earnings should be counted.</p> <p>Reference Section 2835, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria for children in care.</p>	<p>I (ABD) E* (MAGI and Non MAGI)</p>	E
CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS	<p>Unearned – income paid by the U.S. Civil Service and Federal Employee Retirement System (FERS) through the Office of Personnel Management (OPM) because of disability, retirement or death. NOTE: Certain disability benefits paid within the first 6 months that an employee last worked are earned income.</p> <p>Use notices or other documents in the individual's possession (other than a check) to verify the gross amount of</p>	<p>I (MAGI and Non MAGI)</p>	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS (cont'd)	the payment. Notices providing the amount of the annuity and the adjusted amount of the annuity are reliable evidence of the gross amount. If an individual's records are unavailable, complete Form 990, Benefits Verification, and direct the inquiry to the following address: Office of Personnel Management Retirement and Insurance Coverage 1900 E. Street, NW Washington, D.C. 20415		
COMMISSION	Earned – A payment, usually a set fee or percentage, made to an employee for his/her service in facilitating a transaction such as buying or selling goods. A commission may be paid in lieu of or in addition to a regular salary. Refer to Wages in this chart. If the payment is recurring, include it when determining representative pay. If not, do not include the pay. Refer to Section 2653 , Prospective Budgeting.	I (MAGI and Non MAGI)	I
CONTRACTED EMPLOYMENT INCOME	Earned – Income received from jobs in which there is a contract or payment agreement. Determine the gross monthly amount by dividing the total amount during the life of the contract by the number of months specified in the contract.	I	I
CONTRIBUTION, GIFT, PRIZE, AWARD	Unearned – Money given to the AU as a gift from individuals or organizations. *ABD: If the contribution is in the form of food, clothing or shelter, value the contribution as ISM, including third party vendor payments resulting in food, clothing, or shelter to the A/R. EXCEPTION: Never include ISM as income for an A/R in LA-D.	*I (ABD and Non MAGI) E (MAGI)	I
DEATH BENEFITS	Unearned – a benefit received as the result of another's death, such as the following:	*I (MAGI and Non MAGI)	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> • Cash or in-kind gifts given by relatives, friends, or a community group to “help out” with expenses related to the death • Inheritances in cash or in kind • Lump sum death benefits from SSA • Proceeds of life insurance policies received due to the death of the insured • RR Retirement burial benefits • VA burial benefits <p>NOTE: Recurring survivor benefits such as those received under Title II (RSDI), private pension programs, etc., are not death benefits.</p> <p>* Death benefits provided to an individual are income to the individual to the extent that the total amount exceeds the expenses of the deceased person’s last illness and burial paid by the individual.</p> <p>Last illness and burial expenses include related hospital and medical expenses; funeral, burial plot, and interment expenses; and other related expenses. Verify all last illness and burial expenses. If verification (e.g., bills, receipts, contact with provider, etc.) cannot be obtained, accept the individual’s signed allegation. If an expense has been incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No follow-up is required if the assumption is applied.</p> <p>Use judgment to determine whether an expense is reasonably related to the last illness and burial. It is expected that related expenses may include such items as new clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc</p>		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
DEEMED INCOME	<p>Unearned – A portion of income of a non- AU or BG member that is applied to the AU.</p> <p>* For ABD Medicaid, there is no deeming in Patient Liability/Cost Share determinations.</p>	I	*
DEFERRED COMPENSATION PLAN	UNEARNED- Money paid regularly from a deferred compensation plan. The money is usually available upon the owner's employment retirement or if the owner attains a certain age.	I(MAGI and Non MAGI)	I
DISABILITY	Unearned – Paid by insurance company or a source other than an employer. Refer to Sick Pay in this chart.	E-MAGI I-Non MAGI	I
DISASTER ASSISTANCE (Presidentially Declared)	Unearned – Government payments for restoration of a home damaged by a disaster.	E	E
DISASTER UNEMPLOYMENT ASSISTANCE	UNEARNED- Unemployment benefits paid to an AU member during a major disaster or catastrophe.	E (ABD and Non MAGI) I (MAGI)	E
DIVERTED INCOME FOR FAMILY MEDICAID	Unearned – Money deducted or diverted by a court order to a third party.	E	N/A
Children in Placement	<p>Unearned – Money that is legally obligated to an AU member by a court order but is diverted at the option of the AU member to a third party.</p> <p>Benefits/support (child support, SSI, RSDI, etc.) of a child in care diverted to the county of custody as designated payee for the benefit and care of the child and are considered the child's benefits/support. Refer to specific type of income for treatment of income.</p>	I	N/A N/A
DIVERTED INCOME FOR ABD MEDICAID	Unearned - Income diverted to a spouse or dependent family member from a NH or CCSP A/R.	I	I
Spouse or Dependent Family Member	Include as unearned income to the spouse or dependent family member		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
A/R	<p>(DFM) to whom the income is diverted in the eligibility and CCSP/ICWP cost share budgets, if the spouse /DFM is a Medicaid A/R. Refer to Section 2554, Diversion of Income.</p> <p>Include as unearned income to the A/R from whom the income is diverted in the eligibility budget. Allow as a patient liability/cost share budget deduction. Verify from the NH, CCSP or A/R's case record. EXCEPTION: Diverted income is included in PL when a community spouse enters LA-D. Refer to Spousal Impoverishment budgeting.</p>	I	E
DIVIDENDS	<p>Unearned – A share of profits received by a policy holder or shareholder.</p> <p>NOTE: Any dividends left to accrue are a resource separate from the resource that is earning dividends.</p> <ul style="list-style-type: none"> • For ABD Medicaid, any dividends earned on countable resources are not counted as income. • For non-FBR COAs, dividends earned on excluded life insurance policies are excluded as income. <p>*For Family Medicaid, dividends earned on life insurance policies are a countable resource.</p> <p>NOTE: Non-participating life insurance policies do not earn/pay dividends. Use Form 106 or other acceptable documents to verify dividends.</p>	*E	*E
DOMESTIC VOLUNTEER SERVICES PAYMTS	Unearned – Payments to volunteers under the federal government program	E	I
EARNED INCOME TAX CREDIT (EITC)	Unearned – A special tax credit which reduces the federal tax liability of	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<p>certain low income working taxpayers. This tax credit may or may not result in a payment.</p> <p>EITC payments can be received as an advance from an employer or a refund from IRS.</p> <p>EITC given as a tax credit (no payment) is not income.</p>		
<p>EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS (Title IV of Higher Education Act Programs)</p>	<p>UNEARNED- Payments for the educational assistance of an AU member enrolled at a recognized institution of post-secondary education, school for the handicapped, vocational program or a program that provides for completion of a secondary school diploma or GED. These programs include Pell grants, State Student Incentive Scholarships, Work-Study programs, etc.</p> <p>Unearned – payments from educational assistance to the A/R. Exclude, regardless of use.</p>	<p>E (ABD, MAGI and Non MAGI)</p>	<p>E</p>
<p>EMERGENCY ASSISTANCE (IV-A)</p>	<p>Unearned – payments for children, including families with children, provided by the state and matched with federal funds. Emergency Assistance is used to meet emergency needs and is not IBON or ABON.</p> <p>NOTE: Georgia does not provide Emergency Assistance payments.</p>	<p>I</p>	<p>I</p>
<p>EMPLOYEE RETIREMENT BENEFITS</p>	<p>Unearned – Individuals/surviving spouse may be eligible for retirement benefits based on previous employment.</p> <p>Explore if the A/R or spouse worked 10 or more years for the same employer.</p>	<p>I</p>	<p>I</p>

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ENERGY ASSISTANCE PAYMENTS	Unearned – Payment or allowance received under federal, state, and local law for the purpose of assisting the AU with the cost of heating and cooling its home. These include HUD and FMHA Utility reimbursements.	E	E
FARM ALLOTMENTS	Unearned – Payments from government sponsored programs such as Agricultural Stabilization and Conservation Services which are a gain or a benefit to the AU.	I	I
FARMING	Earned – Income received from agricultural labor. Refer to Section 2415, Self Employment .	I	I
FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS	<p>Unearned – food and shelter assistance provided in cash or in kind in emergency disaster situations.</p> <p>Exclude if the assistance is designated as home energy assistance or support and maintenance assistance.</p> <p>Otherwise, contact the State Medicaid Unit for further instructions.</p>	E	E
FEDERAL PROGRAMS, MISCELLANEOUS	<ul style="list-style-type: none"> • Federal Housing Assistance • Food Stamps • Food Programs with federal involvement for Older Americans • Refugee Cash Assistance, Cuban and Haitian • Entrant Cash Assistance and federally reimbursed general assistance payments to refugees • Refugee reception and placement grants and refugee matching grants • Relocation Assistance <p>NOTE: Contact the State Medicaid Unit if there is a payment that is not on this list and it is questionable as to whether it should be excluded or counted.</p>	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
FLEXIBLE BENEFITS	Earned – Refer to Wages in this chart.	I	I
FOSTER CARE PAYMENTS (IV-B or Title XX)	Unearned – per diem payments received by the foster parents to provide for the needs of the foster child and foster family.	E	E
FOSTER CARE PAYMENTS (IV-E)	Unearned – per diem payment received to provide for the needs of the foster child. Exclude as income to the foster child.	E	E
FOSTER GRANDPARENTS PROGRAM PAYMENTS	Unearned – payments received for voluntary service under the federal government (ACTION)	E	I
GARNISHMENT	Earned/Unearned – A set amount of wages or monies withheld by an employer/entity to pay a debt owed to a third party.	I	I
GUARDIANSHIP, ENHANCED SUBSIDIZED AND SUBSIDIZED	Financial support for a child who was in the custody of DHR and guardianship is awarded to a relative or non-relative foster parent(s). Income is not attributed to the child. Reference Section 2848 – Relative Care Placement for additional information.	E	E
GENERAL ASSISTANCE (GA) PAYMENTS	Unearned – payments received by the A/R from county funds administered by DFCS. Consider as Assistance Based on Need (ABON).	E	E
GENERAL ASSISTANCE VENDOR PAYMENTS	Unearned – GA paid directly to the provider if paid for housing expenses including GA paid for transitional housing for the homeless and if paid for energy or utilities.	E	E
GRANDPARENTS RAISING GRANDCHILD-REN	TANF lump sum payment in the amount of three times the eligible grant amount for the AU size.	ABD-I* FM-E	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EMERGENCY/ CRISIS INTERVENTION SERVICES	This payment is used to help pay for the cost of emergent needs incurred by the grandparents when the children come to live with them. *For ABD Medicaid, do not deem GRG income of the A/R's parent or spouse to the A/R.		
GRANDPARENTS RAISING GRANDCHILD-REN SUBSIDY PAYMENT	UNEARNED-TANF Subsidy in the amount of \$50.00 per child per month used assist low income (fixed income) grandparents (60+) to cover additional expenses associated with rearing their grandchildren. *For ABD Medicaid, do not deem GRG income of the A/R's parent or spouse to the A/R.	ABD-I* FM-E	I
GRANDPARENT PAYEE	* The Grandparent payee's income is not counted in the TANF budget. The children's TANF income is not counted in the Grandparent Payee's ABD Medicaid budget	*	*
HEALTH REIMBURSEMENT ACCOUNT	An account through an employer which may only be used to reimburse individuals for certain medical services. * Count any income received in excess of the incurred expense(s) as unearned income.	*E	*E
HOME PRODUCE	Unearned–home produce used for personal consumption and not offered for sale.	E	E
HOUSING AND DEVELOPMENT (HUD) RENTAL REFUND	Unearned – Payment received by the AU for rent. Payments are often distributed by the Georgia Residential Financial Authority (GRFA). Payments can be made directly to the AU, by a two-party check or directly to the landlord on behalf of the AU.	E	E
HOUSING AND URBAN DEVELOPMENT (HUD) OR FARMERS HOME ADMINISTRATION	Unearned – Utility reimbursement provided by HUD and FMHA to AUs who receive housing assistance and are responsible for paying their utilities separately from their rent.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
(FMHA) UTILITY REIMBURSEMENT	Payments can be paid directly to the AU, by a two-party check or directly to the utility company on behalf of the AU.		
INCOME BASED ON NEED (IBON)	<p>Unearned – Assistance provided under a program that considers other income as a factor in determining eligibility and is funded wholly or partially by the federal government or a non-governmental agency for the purpose of meeting basic needs (TANF, SSI, VA Pension, etc.).</p> <p>Continued next page.</p>	See specific type of IBON	See specific type of IBON
INCOME BASED ON NEED (IBON) (cont.)	NOTE FOR ABD: Do not allow the \$20 general exclusion to IBON. Do not deem IBON received by the A/R's spouse or parent to the A/R.		
INCOME TAX REFUND	*Refer to the Chapter 2300, Resources, to determine how to count income tax refunds. For how to count in PL/CS, refer to Section 2552, PL/CS Deductions.	*	*
INDIAN LAND GRANTS	Unearned – Federal distributions to members of Indian Tribes.	E	E
INDIAN GAMBLING ACT PAYMENTS	<p>Tribally managed gaming revenues</p> <p>* If the funds have NOT been held in trust by the Secretary of the Interior, count as unearned income. If held in trust by the Sec. of Interior, exclude.</p>	*	*
INHERITANCE	<p>Unearned– cash, a right or non-cash item(s) received as a result of someone's death.</p> <p>Exclude expenses for the last illness & burial of the deceased if paid by the inheritor.</p> <p>NOTE: Until an item or right has a value or is accessible, it is neither income nor a resource.</p>	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
IN-KIND ITEMS RECEIVED IN LIEU OF WAGES	Earned – Wages may include the value of food, clothing, shelter or other items provided in lieu of cash wages.	I (ABD) E (MAGI and Non MAGI)	E
IN-KIND SUPPORT AND MAINTENANCE	Unearned – Any gain or benefit that is not in the form of money payable directly to the AU such as meals, clothing, produce or housing. * Refer to Section 2430 , Living Arrangements and In-Kind Support and Maintenance.	*I (ABD) E (MAGI and Non MAGI)	E
INSURANCE BENEFITS DUE TO LOSS OF INCOME	Unearned – benefits paid from an insurance policy due to loss of income. * Refer to Section 2230 , Third Party Resources, for information on benefits paid to cover medical expenses.	*I	*I
INTEREST	Unearned – Income paid from bank account deposits, life insurance or other financial instruments/investments. FAMILY Medicaid: Annualize for prospectively budgeted AUs to determine a monthly amount. *Exclude amounts of \$1.00 or less per month. ABD Medicaid: The following types of interest earned on countable resources are excluded as income in the eligibility and PL/CS budgets: <ul style="list-style-type: none"> • Interest earned on all countable financial instruments, such as checking/savings accounts, CDs, etc. • Interest earned on countable Patient Fund Accounts. *Exception: Interest portion of payment made on contracts are counted as income. *NOTE: If total interest earned on excluded resources is \$20/month or	Family *I ABD-E*	E*

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	less, exclude in the Medicaid eligibility and AMN spenddown budgets. If total interest earned on excluded resources exceeds \$20/month, include all the interest in the eligibility and spenddown budgets. See exceptions below.		
INTEREST Burial Contracts Burial Funds	Exclude interest earned on the excluded portion of a burial contract for FBR A/Rs. Exclude all interest earned on a burial contract for non-FBR A/Rs if left to accrue. Exclude interest earned on the excluded portion of funds set aside for burial for FBR A/Rs. Exclude interest earned on the first \$5000 of funds set aside for burial for non-FBR A/Rs if left to accrue.	E E E E	E E E E
INTEREST Dividends	Exclude interest earned on the dividend accumulations from excluded life insurance policies for ABD Medicaid non-FBR A/Rs. For Family Medicaid include interest earned on life insurance policies, stocks and mutual funds. For ABD Medicaid exclude as income dividends/interest earned on countable resources such as stocks and mutual funds.	E I E	E I E
IRREGULAR/ INFREQUENT INCOME	Earned and Unearned – Income that is received too infrequently or irregularly to be anticipated, regardless of the amount. Refer to Section 2504 for definition of irregular or infrequent income. Treat such income as the following: <ul style="list-style-type: none"> • Earned income of \$30 or more received over a three month period • Earned income of less than \$30 received over a three month period 	I E-ABD I-Family E-ABD	I I I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> Unearned income of less than \$60 received over a three month period Unearned income of \$60 or more received over a three month period	I-Family I	I
JAPANESE – AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS (PL 100-383)	Unearned – Restitution payments made by the U.S. Government to Japanese-Americans and Aleutians or their survivors as a consequence of their evacuation, relocation and internment during World War II.	E	E
JURY DUTY	Earned – Compensation received for serving on a jury.	I	I
LOANS FROM OTHERS (PERSONAL OR BUSINESS): A/R is making payments	Unearned – Money received that the borrower has an obligation to repay. Requires a prepayment agreement (written or oral).	E	E
LOANS TO OTHERS (Payment made to A/R)	Unearned - Money loaned to persons outside the AU where a repayment agreement exists. Payments received are considered income. * ABD Medicaid refer to Section 2313 .	I *	I*
LOTTERY WINNINGS	Unearned – A sum of money received as a result of purchasing a winning ticket in a game of chance. * Refer to the appropriate sections on Lump Sum budgeting for Family Medicaid or ABD Medicaid.	*	*
LUMP SUM Children in Placement	Unearned – A sum of money that is received at one time. This may be an accumulated amount or a one-time occurrence. * Count as income in month of receipt. Any remainder is counted as a resource beginning the month after receipt (refer to Resources Chart 2399.1, Lump Sums). For all AFDC related categories of Medicaid, a lump sum is treated as income in the month received and as a resource in any amounts thereafter.	*	*

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
MANAGED INCOME	<p>Unearned – Money legally due the AU that is paid to a protective payee even if the payee is not a member of the AU or resides elsewhere.</p> <p>***** *****</p> <p>Unearned – Money received by the AU for the care and maintenance of an individual not in the AU.</p> <p>Include as income to the individual entitled to the income. Exclude as income to the protective payee.</p> <p>NOTE: Exclude as income to the AU if the protective payee is not making payments to or for the AU.</p>	<p>ABD – I</p> <p>FM – I</p> <p>*****</p> <p>****</p> <p>ABD – I</p> <p>FM – I</p>	<p>I</p> <p>*****</p> <p>*</p> <p>I</p>
MILITARY ALLOTMENTS	<p>Unearned – payments received for quarters, rations, and clothing are subject to deeming.</p> <p>In ABD Medicaid, Furnished on-post housing is subject to the PMV rule as ISM but is not subject to deeming.</p> <p>In Family Medicaid, consider the income as child support if for a dependent child.</p> <p>Only base pay is earned income.</p>	<p>I</p>	<p>I</p>
MILITARY PAY	<p>Military personnel benefits as reported on Leave and Earnings Statement (LES). Refer to Section 2420, Military Pay.</p>	<p>I</p>	<p>I</p>
<p>MILITARY RETIREMENT</p> <p>Air Force</p> <p>Army</p>	<p>Unearned – income received by military retirees and survivors. Beneficiaries who may be entitled to receive military payments include the retiree, his/her surviving spouse and children.</p> <p>Direct inquiries to :the Military Finance Centers as shown below:</p> <p>Parallel FO: 388 AFAFC/XSP Denver, CO 80279</p>	<p>I</p>	<p>I</p>

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
<p>Marine Corps</p> <p>Navy</p>	<p>USAFAC Director, Retired Operations Indianapolis, IN 46246 ATTN: Management Support Office</p> <p>Parallel FO: D24 Marine Corps Finance Center 1500 E. 95th Street Kansas City, MO 64197</p> <p>Parallel FO: D24 Retired Pay Department Code 305, Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199</p>		
MILITARY RETIREMENT LUMP SUM	Unearned – Consider as unearned income in the month or receipt. Treat as a resource the month following the month of receipt.	I	I
MONTGOMERY GI BILL PAYMENTS	<p>UNEARNED-VA payments for individuals enrolled in Active Duty or the Selected Reserve of the Army, Navy, Air Force, Marine Corps, Coast Guard, or Air National Guard for up to 36 months of education assistance.</p> <p>NOTE: Any portion of funds that come from the individual's earnings is counted as income.</p>	E	E
NATIONAL EMERGENCY GRANT (DISASTER RELIEF EMPLOYMENT)	UNEARNED-Grants funded by FEMA, used to provide disaster relief employment on projects that provide food, clothing, shelter and other humanitarian assistance for disaster victims.	E	E
NATIONAL FLOOD INSURANCE PAYMENTS	UNEARNED- Payments made for flood mitigation activities under the National Flood Insurance Act of 1968.	E	E
NOISE ABATEMENT PAYMENTS	Unearned – Non-recurring payment designated for noise abatement work on a dwelling.	E	E
OLDER AMERICANS ACT/ SENIOR COMMUNITY SERVICE	Earned – Title V income paid for community service employment to individuals 55 or over. This includes Green Thumb income. Anything provided under these programs other	<p>ABD - I</p> <p>FM - E</p>	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EMPLOYMENT PROGRAM	than a wage or salary is excluded income.		
OVERTIME PAY	EARNED- Extra income paid to employees who work in excess of 40 hours in a week. Refer to Wages in this chart.	I	I
PENSIONS	Unearned – A payment received regularly as a retirement benefit.	I	I
PUBLIC LAW 103-286 - PAYMENTS to VICTIMS of NAZI PERSECUTION (examples, including but not limited to the following: German Reparation, German Pensions for Work in Ghettos	Unearned – any payments made to individuals because of their status as victims of Nazi persecution under Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 Such payments are disregarded in determining eligibility for any amount of benefits/services provided under any Federal or federally assisted program based on need,.	E	E
Qualified Income Trust (QIT)	Income placed in a QIT allows for income eligibility under ABD LA-D COAs. Refer to Section 2407.	Family – N/A ABD LA-D COAs – E All other ABD COAs – N/A	I
Qualified Tuition Savings Programs (529 Plans)	A savings plan for higher education Refer to Section 2344 .	E	E
RAILROAD RETIREMENT (RR)	Unearned – retirement, survivors or disability income paid to former railroad employees and /or their dependents. Use gross RR and/or RSDI, including the amount paid as a Medicare premium. * For ABD Medicaid, refer to Section 2552 , Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost	I	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RAILROAD RETIREMENT (RR) (cont'd)	<p>share budget.</p> <p>Consider a benefit augmented for dependents as income to the beneficiary, not the dependent.</p> <p>If the A/R's SSN begins with a 7, the individual is likely to be eligible for RR.</p> <p>If the A/R's deceased spouse worked for a railway system, the A/R may be eligible, even if remarried.</p> <p>RSDI and RR may be combined in one check. If so, verify RSDI via SSA and RR through the Railroad Retirement Board.</p> <p>To obtain written verification of the benefit amount, complete Form 990 and mail to:</p> <p>Benefits Verification Railroad Retirement Board 401 W. Peachtree Street, Room 1702 Atlanta, GA 30365-2550</p>		
REFUNDS FROM DCH	Unearned – A refund of excess proceeds from a TPL after Medicaid and the TPL have paid a medical expense claim in full.	I	I
REIMBURSEMENT	Unearned - Payment for an expense that does not represent a gain or benefit to the AU.	E	E
RELATIVE CARE SUBSIDY	<p>Unearned - Financial support for children placed with an approved relative caregiver.</p> <p>A child may or may not be in DFCS custody for relative caregiver to qualify for certain subsidies.</p>	E	E
RELOCATION ASSISTANCE	Unearned – Money paid under Title II of the Uniform Relocation Assistance & Real Property Acquisition Policies Act of 1970.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RENTAL INCOME	<p>Earned or unearned – Money received on property owned by an AU member and rented to others.</p> <p>Earned – Must be engaged in management of property an average of 20 hours per week.</p> <p>Unearned – If not involved in management more than 20 hours per week.</p>	I Family-May deduct expenses from maintaining and handling of property	I May deduct expenses from maintain-ing and handling of property
REPAYMENT OF OVERPAYMENT OF BENEFITS THROUGH BENEFIT REDUCTION IN TANF, SSI, RSDI, UCB (or others)	<p>FAMILY MEDICAID: Unearned – Money withheld from the income source to repay a previous overpayment.</p> <p>Do not count the repayment amount. Count the gross minus the repayment amount.</p> <p>* ABD MEDICAID: Refer to RSDI Recoupment Amount and SSI Recoupment Amount in this chart.</p>	FM – E ABD - *	*
RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)	Unearned – A federal volunteer services program.	E	I
RETIREMENT	Unearned – A sum of money paid regularly as a retirement benefit.	I	I
RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI) (Also referred to as TITLE II BENEFITS or Social Security Benefits)	<p>Unearned – Social Security benefits paid to an insured worker or dependent on the basis of the retirement, death or disability of the worker.</p> <p>Use the gross entitlement (before the Medicare Part B premium is deducted) in the eligibility budget.</p> <p>* For ABD Medicaid, refer to Section 2552, Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget.</p>	I (Non-MAGI) I* (MAGI)	I*

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
<p>RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI) (Also referred to as TITLE II BENEFITS or Social Security Benefits) (cont'd)</p>	<p>Count the entire RSDI lump sum payment as income for the month of receipt.</p> <p>NOTE: Refer to Chart 2399.2 – Resource Treatment of Income Retained after the Month of Receipt, for instructions on how to treat any portion of a RSDI lump sum retained after the month of receipt.</p> <p>Do not count refunded Medicare Part B premiums as unearned income.</p> <p>*For MAGI COAs RSDI of a tax dependent/child who has no other source of income AND resides with a parent is <u>excluded</u>. RSDI for a tax dependent/child is countable <u>only</u> if the tax dependent/child has other income that meets the IRS tax filing threshold or if the child does not reside with a parent and is not claimed as a tax dependent by his/her parent. Refer to Section 2610.</p>	<p>I (Non-MAGI) I* (MAGI)</p>	<p>I*</p>
<p>REVERSE MORTGAGE</p>	<p>Unearned – allows a homeowner to borrow, via a mortgage contract, a portion of the appraised value of the home. The homeowner then receives a periodic payment (or a line of credit) which does not have to be repaid as long as the borrower lives in the home. Reverse Annuity Mortgages (RAMs) involve the purchase of an annuity. In most reverse mortgages, the original loan does not need to be repaid until the homeowner dies, sells the home, or moves.</p> <p>The HEC plans connected with HUD through the Federal Housing Authority are reverse mortgages.</p> <p>Treat as loan proceeds</p> <p>Annuity payments from a RAM</p>		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ROOMER	Earned – Direct payments for room only.	I	I
RSDI RECOUPMENT AMOUNT	<p>Unearned – an amount withheld from an individual’s monthly RSDI check by SSA to recover an overpayment of RSDI benefits to the individual</p> <p>*Refer to Repayment of Overpayment of Benefits on Page 2499-21.</p>	<p>ABD – I</p> <p>FM – E*</p>	E
SALE – LEASEBACK	<p>Unearned – the homeowner transfers title of the home to a buyer (e.g., an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. The difference between payments on the installment note and the rental cost provides the former homeowner with cash. Under this arrangement, the buyer is responsible for the payment of real estate taxes, major maintenance, and casualty insurance. Some sale-leaseback arrangements involve the purchase of an annuity.</p> <p>Treat as the conversion of a resource, not as income.</p> <p>Interest earned from an installment note</p> <p>Annuity payments</p>	<p>E</p> <p>I</p> <p>I</p>	<p>E</p> <p>I</p> <p>I</p>
SCHOOL LUNCH PROGRAM	UNEARNED-The cash value of assistance provided to children under the National School Lunch Program, Child Nutrition Act, Special Milk Program, or School Breakfast program.	E	E
SELF EMPLOYMENT	Earned – income from a self employed enterprise.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EARNINGS (NET)	Refer to Section 2415, Self-Employment .		
SENIOR COMPANION PROGRAM	Unearned – payments to volunteers under a federal government program	E	I
SEVERANCE PAY	Earned – Money received from former employer upon termination of employment. Unearned- payments received from a former employer after termination of employment.	I	I
SHARED HOUSEHOLD EXPENSES	Payments made to an AU by a person who shares household expenses, and which do not represent a gain or benefit to the AU. Consider UNEARNED income for Family Medicaid. Refer to Section 2430, In-Kind Support and Maintenance , for ABD Medicaid.	E	E
SHELTERED WORKSHOP / WORK ACTIVITY CENTER PAYMENTS	Earned – payments received for work performed in a sheltered workshop or work activity center.	I	I
SICK PAY	Sick Pay is a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability. Unearned – Any payments for sickness and accident disability paid more than 6 months after work stopped because of sickness or disability or sick payments made from the employee's own contributions are unearned income.	I I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
SICK PAY (cont'd)	<p>Earned – If paid from employer's payroll.</p> <p>Unearned – Paid by insurance company or a source other than an employer.</p>	<p>I</p> <p>E (MAGI) I (Non MAGI)</p>	
SPECIAL AND DEMONSTRATION VOLUNTEER PROGRAMS	Unearned – Payments to volunteers under a federal government program	E	I
SPENDING ACCOUNT	EARNED-Pre-taxed earnings that are deducted from an employee's gross wages and placed in an account to pay AU expenses such as childcare and medical costs.	I	I
STRIKE BENEFITS	Unearned – Income received by individuals on strike.	I	I
SUPPLEMENTAL SECURITY INCOME (SSI)	<p>Unearned – monthly payments made to aged, blind or disabled individuals from the federal government. SSI is administered by the Social Security Administration. Consider as Income Based on Need (IBON). SSI recipients also receive Medicaid.</p> <p>* For ABD Medicaid, do not deem the ineligible parent or spouse's SSI income to the A/R. However, include SSI in the Couple eligibility budget when one member of the couple is AMN and the other receives SSI.</p> <p>** Refer to Section 2578, SSI Recipients, for information on including SSI income in nursing home patient liability budgets.</p>	<p>ABD-*I</p> <p>FM – E</p>	**I
SSI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly SSI or RSDI check by SSA to recover an overpayment of SSI benefits to the individual.	<p>ABD – I</p> <p>FM – E</p>	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> Exclude a SSI recoupment from a SSI check, but include a SSI recoupment from an RSDI check, in the patient liability budget. <p>For Family Medicaid, refer to Repayment of Overpayment of Benefits through Benefit Reduction in TANF, SSI, RSDI, UCB or others on page 2499-19.</p>		
SUSAN WALKER VS BAYER CORPORATION SETTLEMENT PAYMENTS	<p>A cash settlement as a result of a class action lawsuit.</p> <p>Unearned</p>	E	E
TAX REFUNDS	<p>A refund of taxes paid on food, income or property. It may be considered as earned or unearned.</p> <p>Earned</p> <p>A refund of federal or state taxes paid on income.</p> <p>Unearned</p> <p>A refund of taxes paid on food or property, such as real property or automobiles.</p> <p>Refer to Section 2405, Treatment of Income.</p> <p>* Refer to Section 2552, PL/CS Deductions.</p>	E	*
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	<p>Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments.</p> <p>TANF benefits received from another state are budgeted for the month of receipt only.</p> <p>*For ABD Medicaid, do not deem TANF income of the A/R's parent or spouse to the A/R.</p>	ABD – I* FM - E	I
TIPS	Earned – Voluntary payments above	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	the stated cost of a product or service given in appreciation for the service rendered. Refer to Wages in this chart.		
TRADE READJUSTMENT ALLOWANCE (TRA)	UNEARNED-Weekly payment available for up to 52 weeks after an individual's UCB is exhausted and during a period in which the individual is participating in a full-time training program approved in accordance with the Trade Act.	I	I
TRAINING ALLOWANCES/ STIPENDS (Refer to WIA for treatment of WIA income)	<p>Earned – Payments received from vocational/ rehabilitation programs recognized by Federal, State, local governments to the extent they are not a reimbursement or specifically excluded.</p> <p>NOTE: If the earnings belong to a child, refer to Child's Earnings in this chart.</p>	I	I
TRANSITIONAL SUPPORT SERVICES (TANF)	<p>UNEARNED- TANF support payment used to pay for or reimburse the cost of childcare, transportation, and incidental expenses to an applicant or recipient. TSS is available for a period of six months beginning with the first month of TANF ineligibility.</p> <p>*For ABD Medicaid, do not deem WSP income of the A/R's parent or spouse to the A/R.</p>	ABD-I* FM-E	I
<p>TRUST FUND PROCEEDS</p> <p>TRUST FUND PROCEEDS (cont'd)</p>	<p>Unearned – Money in a trust fund.</p> <p>* If the trust is not a Medicaid Qualifying Trust (MQT), include as income only those trust proceeds actually provided to the A/R by the trustee.</p> <p>* If the trust is an MQT, refer to Section 2336, Trust, Medicaid Qualifying, for information on how to treat the trust proceeds.</p> <p>Verify by a copy of the trust document</p>	<p>*I</p> <p>*I</p>	<p>*I</p> <p>*I</p>

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	and contact with the trustee.		
UNEMPLOYMENT COMPENSATION BENEFITS (UCB)	<p>Unearned – Benefits received from the Department of Labor (DOL) by unemployed individuals. Usually received weekly. Continue to count until notified by the A/R of termination.</p> <p>Use DOL Clearinghouse for verification of the amount and date of weekly benefits.</p>	I	I
UNION FUNDS	Unearned – Refer to Strike Benefits in this chart.	I	I
UNIVERSITY YEAR FOR ACTION (UYA)	Unearned – payments received under a federal volunteer services program.	E	I
UTILITY PAYMENT (HUD SECTION 8/GRFA/FMHA)	Unearned - *Refer to Housing and Development (HUD) in this chart.	*	*
VACATION PAY	Earned – Any amount paid to employees for a regular scheduled period spent away from work or regular duty. It includes amounts paid even if the employee chooses not to take a vacation. Refer to Wages in this chart.	I	I
VENDOR PAYMENT	<p>UNEARNED-Money paid by an outside source to a third party on behalf of the AU for an expense.</p> <p>Personal expenses paid for by another person that does not make up for a loss caused by that person.</p> <p>Personal expenses paid for by another person that makes up for a loss caused by that person, and only restores the individual to a position before the loss.</p>	E	E
VENDOR PAYMENT (cont'd)	Housing assistance payments made by a state or local government to a third party on behalf of an AU residing in transitional for the homeless.	E	

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<p>NOTE: If the vendor payment is made with GA funds, refer to General Assistance Vendor Payments in this chart.</p> <p>NOTE: For ABD Medicaid, consider possibility of ISM. Refer to Section 2430.</p>		
VETERANS ADMINISTRATION (VA) BENEFITS	Refer to Section 2418 – VA Income for a description of the different types of VA income.		
VA PENSION	<p>Unearned</p> <p>VA pensions are IBON and are not entitled to the \$20 general exclusion. (Section 2505)</p>	ABD-I FM-E	I
VA COMPENSATION	<p>Unearned</p> <p>VA compensation is not IBON.</p> <p>EXCEPTION: Compensation received by parents due to the service connected death of their child is IBON.</p>	ABD-I FM-E	I
VA EDUCATIONAL BENEFITS	Unearned	ABD – I FM – E	E
Other VA Benefits Which are NOT Included As Income in the Eligibility Determination	<p>Aid and Attendance</p> <p>Unusual Medical Expense (UME) reimbursement & Continuing Medical Expense (CME)</p> <p>Housebound Allowance</p> <p>Clothing Allowance</p>	E E E E	E E E E
Augmented VA Benefits	<p>Unearned</p> <p>*Refer to Section 2418, VA Income for specifics on counting Augmented VA income.</p> <p>NOTE: Any portion of a VA check augmented for dependents is income to</p>	ABD-*I FM-E	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	the dependent(s).		
Augmented VA Benefits To NH/CCSP A/Rs	Unearned * Refer to Section 2418 , VA Income for specifics on counting Augmented VA income for LA-D A/Rs. NOTE: Augmented VA benefits are treated differently than augmented RR benefits. The entire amount of an augmented RR check is income to the beneficiary.	ABD-*I FM-E	*I
VA Recoupment	Repayment of VA benefits which are deducted from the VA check.	I Count the gross amount for eligibility determination FM-E	E Count the gross less recoup-ment
VA Lump Sum	Unearned <ul style="list-style-type: none"> Any portion of a VA lump sum that is not VA Aid and Attendance, is not VA UME reimbursement or is not augmented is counted as unearned income for the month of receipt. 	ABD-*I FM-E	*I
VICTIM RESTITUTION VICTIM RESTITUTION (cont'd)	Unearned – Money received by a victim of a crime from a crime victim restitution program, usually a reimbursement for financial losses. <ul style="list-style-type: none"> The value of the payment does not exceed the value of the loss The value of the payment exceeds the value of the loss. Count the excess value as income in the month of receipt. 	E E I	E E I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> The payment is a set monthly amount based on a court ruling. Count as income in the month of receipt. 	I	I
VISTA VOLUNTEER PAYMENT	Earned – Income received by VISTA volunteers under Title I of the Domestic Volunteer Services Act. Included are payments from the Urban Crime Prevention Program	E	E
VOLUNTEER PAYMENT RSVP Foster Grandparent/ VISTA Urban Crime Prevention	<p>Unearned – Title II of Domestic Volunteer Services Act of 1973</p> <p>Unearned – Payments from Title I. Exclude only if the A/R was receiving FS or AFDC at the time they joined Title I even if there is a break in participation.</p>	E	I
WAGES (SALARIES) Children in Placement	<p>Earned – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis.</p> <p>Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee’s share of FICA when paid by the employer. Reference Section 2835, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria.</p>	I	I
WORKER’S COMPENSATION	<p>Unearned – payments awarded to injured employees or to their survivors. Exclude any portion designated for medical, legal, or related expenses paid or deducted and not controlled by the A/R in connection with claim.</p> <p>Verify from the employer or from the source of the payment.</p>	ABD-I FM-E	I
WORKFORCE INVESTMENT ACT	Earned – Income received while working as part of a WIA program.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
WORK STUDY PROGRAM (Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	E	N/A
WORK STUDY PROGRAM (Non-Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	I	N/A
WORK SUPPORT PAYMENTS (WSP)	A time limited cash supplement to a TANF assistance unit that, because of employment, either becomes ineligible for TANF or experiences a reduction in its TANF benefit amount and declines ongoing TANF in order to stop the TANF clock. *For ABD Medicaid, do not deem WSP income of the A/R's parent or spouse to the A/R.	ABD-I* FM-E	I
YOUTH BUILD PROGRAM PAYMENTS	EARNED- Payments made through the Youth Build Program. *See WIA for treatment of this income.	I*	I*
YOUTH PROJECT PAYMENTS	Unearned – Payments made through projects developed to assist youth in acquiring work skills including the following: <ul style="list-style-type: none"> • Youth incentive entitlement pilot project • Youth community conservations and improvement projects • Youth employment *See WIA for treatment of this income.	I*	I*

CONVERSION CHART

IF PAID	THEN
HOURLY	Multiply the number of hours worked per week times the hourly wage times 4.3333 weeks;
WEEKLY	Multiply gross income times 4.3333;
BI-WEEKLY	Multiply bi-weekly gross income times 2.1666;
SEMI-MONTHLY	Multiply semi-monthly gross income times 2;
YEARLY	Divide yearly gross income by 12.

Revised
04/01/15

220% FEDERAL POVERTY GUIDELINES

FPL 2016 for Pregnant Woman Medicaid		
Budget Group	220%	Plus 5%
1	\$2,178	\$2,228
2	\$2,937	\$3,004
3	\$3,696	\$3,780
4	\$4,455	\$4,557
5	\$5,214	\$5,333
6	\$5,973	\$6,109
7	\$6,735	\$6,889
8	\$7,498	\$7,669
9	\$8,262	\$8,450
10	\$9,023	\$9,229



MEMORANDUM

To: Dr. Rony Francois, Director
Office of State Operations, Division of Public Health

From: Yvonne Greene, Eligibility Program Director 2
Medicaid Eligibility Policy (DCH)

Date: November 15, 2010

Subject: Public Health's Presumptive Eligibility on GAMMIS

On November 1, 2010 the Department of Community Health transitioned to a new Medicaid information system. Hewlett Packard Enterprise Services (HP) replaced Affiliated Computer Systems (ACS) as the fiscal agent for the Medicaid Management Information System (MMIS).

The new HP MMIS will be known as the Georgia Medicaid Management Information System or GAMMIS. This memorandum is to provide the Division of Public Health (PH) with new HP contact information for Presumptive Eligibility (PE) Pregnancy Medicaid and Women's Health Medicaid.

Member Identification Cards

All Georgia Medicaid members will receive new member ID cards. The Medicaid card will have information which coincides with the new GAMMIS contract with HP Enterprise Services. The new cards will be distributed via mass mailing by the end of October 2010.

Members that were already known to the system will continue eligibility with the previously assigned 111 Medicaid ID number; however, members approved for the first time on or after 11/1/10 will receive a Medicaid ID number beginning with 222.

Member/Provider Contact Center

The **HP Member Contact Center** will be available via phone Monday through Friday (excluding state holidays) from 7 am to 7pm at 770-325-2331 local or toll free outside metro area at 1-866-211-0950.

The **HP Provider Contact Center** will be available via phone Monday through Friday (excluding state holidays) from 7 am to 7pm at 770-325-9600 local or toll free outside metro area at 1-800-766-4456.

Dr. Rony Francois
Page 2
November 9, 2010

Members/Providers can access eligibility information via GAMMIS web portal at www.mmis.georgia.gov or the Interactive Voice Response System (IVRS) at 770-111-4456 (Providers) and at 1-866-211-0950 (Members).

The Presumptive Eligibility (PE) Corrections email box will be deactivated effective November 30, 2010 as all documents requiring updates must be scanned and completed by HP. PH will call the Provider Contact Center for any GAMMIS updates needed or fax form 632 or 632W for updates to HP at **1-866-483-1044**.

Presumptive Eligibility Manual

The PE manual was not updated by ACS for 10/10; however, it is currently located at: <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Presumptive%20Eligibility.pdf>. A few updates will be completed in the near future to correctly update the manual with HP and GAMMIS information only; there are no changes in policy.

Forms

Requests for DMA forms can be submitted using the Contact Us feature located in GAMMIS web portal or by contacting the HP mailroom supervisor, Milton Giles, at 770-492-5387.

Please distribute to all State Office Staff, supervisors and members of the PH team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson at 404-463-0521.

cc: Jon Anderson, Deputy Chief, Member Services & Policy
Isabel Blanco, DHS/DFCS Executive Director
Kathy Herren, DHS/DFCS Deputy Director Programs & Policy
Lynne Boring, Operations Director, DHS Office of Family Independence
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, Director, DHS Right from the Start Medicaid
Mandy Corlee, Project Manager, DHS Right from the Start Medicaid
Sophia Jefferies, Program Consultant, Division of Public Health
Cathy Broom, Program Consultant, Division of Public Health
Lynnette Rhodes, DCH Legal Services



MEMORANDUM

TO: Dr. Rony Francois, Director
Office of State Operations, Division of Public Health

FROM: Yvonne Greene, Eligibility Program Director 2 
DCH Medicaid Eligibility & Policy

DATE: December 7, 2010

SUBJECT: Planning for Healthy Babies (P4HB) – Family Planning Waiver

The Planning for Healthy Babies (P4HB) waiver covers Family Planning services to women ages 18 through 44 who are at or below 200 percent of the federal poverty level (FPL), who are not covered by insurance including Medicare and not otherwise receiving benefits under another Medicaid program. P4HB covers Inter-Pregnancy Care (IPC) services, including primary care case management, for eligible women who have delivered a very low birth weight baby (VLBW). Women, actively receiving Medicaid, that have delivered a very low birth weight baby, may receive services in the Resource Mother component of P4HB. P4HB is a five-year term demonstration waiver scheduled to begin January 1, 2011 and end in December 31, 2015.

The primary goals of the P4HB program are to reduce: Georgia's low birth weight (birth weight less than 2500 grams) and very low birth weight (birth weight less than 1500 grams) rates; the number of unintended and high-risk pregnancies in Georgia; and Georgia's Medicaid costs by reducing the number of unintended pregnancies.

There are three levels of service under P4HB – Family Planning Services, Inter-Pregnancy Care Services, and Resource Mother Services.

Family Planning Services

P4HB extends eligibility for Family Planning services to women aged 18 through 44 years who are at or below 200 % of the most current FPL. All women are potentially eligible to meet the program requirements for Family Planning services.

Family Planning services include medically necessary services and supplies related to birth control and pregnancy prevention. Services include contraceptive management with a variety of methods, patient education, counseling, and referral as needed to other social services and health care providers

Women approved for P4HB will receive Family Planning services such as:

- Family planning exams
- Birth control services and supplies including tubal ligations
- Health education and counseling
- Follow up visits with your family planning doctor or nurse
- Counseling and referrals to community agencies and health care providers
- Family planning lab tests such as pregnancy tests and pap smears
- Screening, treatment and follow up for STDs (except HIV/AIDS and Hepatitis) discovered during your family planning exam
- Vitamin B9 (which is Folic Acid) supplements
- A Tetanus, Whooping Cough, and Diphtheria booster if you are age 20 or younger and are due for a booster
- Hepatitis B vaccine if you are age 20 or younger and have not received this vaccine before

Women enrolled in Family Planning services will have access to the family planning providers only, and must enroll in a care management organization (CMO) prior to obtaining services.

All pregnant women members receiving any Medicaid Class of Assistance (COA) will receive a letter in their eighth month of pregnancy informing them of the P4HB program, along with a P4HB application. The Department of Community Health's goal is for all Medicaid COA cases terminating will have a Continued Medicaid Eligibility (CMD) process completed; specifically the Right From the Start (RSM) Pregnant Women would have a seamless transition into the P4HB program after their 60 day transitional Medicaid ends, if they are ineligible for any Medicaid program. RSM Pregnant Women approved for P4HB may continue to use their same CMO of either WellCare, Peach State or Amerigroup. P4HB women may contact the CMO for additional information.

WellCare: georgia.wellcare.com or
call **1-866-231-1821 (TDD/TTY 1-877-247-6272)**

Peach State: www.pshp.com or
call **1-866-704-1484 (TDD/TTY 1-800-659-7487)**

Amerigroup: www.myamerigroup.com or
call **1-800-600-4441 (TDD/TTY 1-800-855-2880)**

P4HB women have the right to change their CMO within the first 30 days of approval. If the member selects a new CMO by the 23rd of the current month, the change will be effective the 1st of the following month.

Inter-Pregnancy Care Services

The P4HB program includes an Inter-Pregnancy Care (IPC) component for women aged 18 through 44 years at or below 200% of the most current FPL who have delivered a VLBW baby as of January 1, 2011.

Women enrolled in the IPC program will have access to the CMO's family planning and primary care providers, some dental services and Resource Mother services. This expanded eligibility will: increase access to Family Planning services by permitting women to use private health care providers as well as county public health departments and community health centers; and reinforce the medical home concept by allowing women to choose their delivering physician or prenatal care provider as their family planning provider.

Resource Mother Services

The P4HB program includes a Resource Mother component for women aged 18 through 44 years at or below 200% for the most current FPL. These women will be actively receiving Medicaid or PeachCare for Kids™ and have delivered a VLBW baby on or after January 1, 2011.

The Resource Mother services will assist these members with:

- Primary Care medical appointments
- Arrange non-emergency medical transportation
- Healthy eating choices and smoking cessation
- Medications to treat chronic health conditions
- Coordination of social services support
- Obtaining regular preventive health visits
- Obtaining immunizations for your child or children
- Finding local resources in your community

PSI will mail the Resource Mother letter to all pregnant women members receiving Medicaid. The Resource Mother component enhances the member's Medicaid or PeachCare for Kids™ coverage and a P4HB application is not required.

P4HB Program Requirements:

- Available to women aged 18 through 44 years who are at or below 200 % of the most current FPL. The current FPL will be based on family size. Eligibility may begin the month that the 18th birth date falls and will end the last day of the month that the 45th birth date falls.

- There is no resource test.
- Are U.S. citizens or qualified Immigrants.
- Must be a Georgia Resident.
- There is no three months prior coverage.
- Standard income deductions apply:
 - \$90 earned income
 - \$50 child support
 - \$200 under age 2 dependent care
 - \$175 over age 2 dependent care
- Eligibility for P4HB IPC services is limited to (24) twenty-four consecutive months. A woman is no longer eligible for P4HB if she reaches the age limit or is no longer able to become pregnant as a result of sterilization, surgical procedure, etc. If this is the case she cannot reenroll in P4HB. If a woman becomes pregnant while enrolled in P4HB, after verification of pregnancy, she may be transitioned into RSM Pregnancy Medicaid as the Continuing Medicaid Determination (CMD) eligibility process. A former pregnant woman may reenroll in P4HB after delivery of her child if she is not eligible for another Medicaid program.
- All pregnant women approved for Presumptive Eligibility (PE) Medicaid should be given P4HB information along with the Women, Infants and Children (WIC) program information.
- Required to report changes within (10) ten days.
- P4HB is subject to an annual review.

P4HB Application and Process

The P4HB PDF application form, poster and resource material are attached and can be printed locally or the Division of Public Health (PH) can email Ms. Duncan at cduncan@dch.state.ga.us to obtain applications, posters and resource material by mail. Each PH office should maintain a supply of applications and resource material on hand at all times. At minimum, all PH lobbies should contain the P4HB poster clearly displayed for the general public.

All applications will be mailed or faxed to Policy Studies, Inc. (PSI) at:

P4HB
P.O. Box 1810
Atlanta, GA 30301-1801

Fax: 1-888-744-2102

Applicants may access an on-line application at www.planning4healthybabies.org.

All changes reported by the applicant or member; any questions regarding P4HB; and all applications and reviews will be completed by PSI. Applicants and members can call toll free 1-877-P4H-B101 (744-2101).

P4HB allows 18 year old females to be in their own case even if they live with their mother as long as she is also active in the P4HB program. Budget groups will be calculated as they currently are which will include the spouse, and their mutual child(ren), (biological or adoptive).

P4HB Aid Categories and New CMO Card

Family Planning- 181; will receive a pink CMO card
Inter-Pregnancy Care- 180; will receive a purple CMO card
Resource Mother Family Medicaid- 182; will receive a yellow CMO card
Resource Mother ABD/SSI Medicaid- 183; will receive a yellow CMO card

Please distribute to all State Office Staff, supervisors and members of the PH team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson at 404-463-0521.

Attachments

cc: Jon Anderson, Deputy Chief, Member Services & Policy
Isabel Blanco, DHS/DFCS Executive Director
Kathy Herren, DHS/DFCS Deputy Director Programs & Policy
Lynne Boring, Operations Director, DHS Office of Family Independence
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, Director, DHS Right from the Start Medicaid
Mandy Corlee, Project Manager, DHS Right from the Start Medicaid
Lynn Campbell, DCH Family Planning Program Manager
Kaprice S. Welch, DCH Women's Service Director
Sophia Jefferies, Program Consultant, Division of Public Health
Cathy Broom, Program Consultant, Division of Public Health
Lynnette Rhodes, DCH Legal Services



MEMORANDUM

To: Dr. Seema Csukas, Interim Program Director
Maternal and Child Health and WIC Programs
Department of Public Health

From: Yvonne Greene, Eligibility Program Director 2 
Medicaid Eligibility Policy (DCH)

Date: March 9, 2012

Subject: Updated Presumptive Eligibility (PE) Changes/Corrections Procedures

The PE Pregnancy manual scheduled for update April 1, 2012 will reflect these changes. These procedures apply to PE Pregnancy Medicaid and PE Women's Health Medicaid.

CURRENT PROCEDURES

Qualified Providers (QPs)/Department of Public Health (DPH) cannot make any changes to an eligible active PE case using the Georgia Medicaid Management Information System (GAMMIS) web portal. Any changes that need to be updated are emailed to pecorrections@dch.ga.gov. Corrections are completed Monday-Friday, 8:00 AM – 5:00 PM.

DCH has not finalized the system fix for PE cases to be entered when a member has an active Planning for Healthy Babies (P4HB) case. The QP/DPH has to fax the 632 or 632W form to Memi Wilson to have the PE manually updated and P4HB closed.

NEW PROCEDURES

Effective immediately, but no later than 4/1/12, QP/DPH will fax required PE correction requests directly to the DCH fiscal agent, HP, using the attached coversheet. Required changes include:

Name
Address
Residential County Code
Social Security Number
Date of Birth
Duplicate ID Merge
Application Date



Dr. Scema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 2

Additional corrections that can be made with any of the required changes listed above include:

- Administrative County Code
- Race
- Ethnicity
- Citizenship
- Expected Birth Date of Fetus
- Number of Births

COVERSHEET

The attached coversheet should be copied and pasted on to your office letterhead. This is the only alteration allowed to this coversheet. This coversheet should only be used to report required corrections to PE cases. The form 632 or 632W must be faxed with this coversheet as page two (2); no additional pages should be attached to the fax for PE corrections.

If the 632 or 632W is not attached, HP will not make the change.

If HP cannot read the 632 or 632W they will attempt one time to contact the person who faxed the request. If no contact is made by QP/DPH, the PE change will not be completed.

The coversheet contains four (4) sections.

1. Identify PE

<u>PRESUMPTIVE ELIGIBILITY CHANGES/CORRECTIONS</u>			
FAX TO: HP Member Enrollment	TODAY'S DATE: _____		
1-866-483-1045			
UPDATE (check one):	<input type="checkbox"/>	PE PREGNANCY Attach Form 632	<input type="checkbox"/>
			PE WHM Attach Form 632W

Add today's date and check which PE program will be corrected. The HP fax number should be used by QP/DPH and the Division of Family and Children Services (DFCS) offices only.

Only one complete fax is needed. Change requests faxed to HP, Monday-Friday, 8:00 AM – 4:45 PM will be completed in three (3) business days.

QP/DPH can access GAMMIS on the Web portal to determine that the change was completed; there will be no notification of the completion.



Dr. Seema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 3

2. Required Changes/Corrections Needed

Name <input type="checkbox"/>
Address <input type="checkbox"/>
Residential County Code <input type="checkbox"/>
Social Security Number <input type="checkbox"/>
Date of Birth <input type="checkbox"/>
Duplicate ID Merge: _____ Original _____ Duplicate
Application Date (only if the application date is in another month) <input type="checkbox"/>

Check the appropriate box(es) on the change(s)/correction(s) as needed. Each of these changes can be found on the attached 632 or 632W form except for duplicate ID numbers.

The following required changes/corrections are needed so the member can receive correct PE services by providers:

Name –member cannot receive prescriptions when the name is spelled wrong and/or the first and last name are reversed.

Address –the Care Management Organizations (CMOs) begin to mail their welcome aboard packets to members using this address. The member has a limited amount of time to choose their CMO, otherwise a CMO will be chosen for them.

Residential County-the Non Emergency Transportation (NET) uses this code to provide services.

Social Security Number- used to match with other systems. If the member needs assistance and does not have their member ID number this is one way the providers/HP/DCH can identify the member.

Date of Birth- if the member needs assistance and does not have their member ID number this is one way the provider/HP/DCH can identify the member.



Dr. Seema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 4

3. Additional changes

Administrative County Code

Race: American Indian or Alaskan Asian Black Caucasian
 Hispanic Other: _____ (specify)

Ethnicity: Hispanic N/A

Citizenship: U.S. Citizen Qualified Immigrant Illegal Immigrant
 Other: _____ (specify)

Expected Birth Date of Fetus

Number of Births

If “additional changes” are the only changes requested do not fax the form to HP. These changes will be updated in GAMMIS when the full Medicaid determination is completed. HP will not make any “additional changes” if there is not a required change/correction.

4. Contact Information

CONTACT INFORMATION:
Name of person completing this form: _____
Please Print Clearly
Direct phone number of person completing this form: _____

The person submitting the form to HP will need to provide a name and direct phone number in this section. This may not necessarily be the person that completed the 632 or 632W form. This section is used if HP or DCH needs to contact this individual to obtain information to update the PE; please print clearly.

PE CORRECTIONS EMAIL BOX

This email box will now be used to report PE cases that cannot be updated due to a system error message given to QP/DPH on the PE Panel screen. All PE should be added to GAMMIS using the web portal. You will not be able to add a PE to the web portal when the member is active for P4HB.



Dr. Seema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 5

QP/DPH may not see the active P4HB when screening on the web portal because the member is not enrolled in a Managed Care Healthy Baby (MCHB) plan. MCHB may be either WellCare, Amerigroup, or Peach State. Until the system fix is completed, you will not be able to add PE on the web portal for an active P4HB member.

If the QP/DPH has the ability to scan the 632 or 632W form they can email the form to pecorrections@dch.ga.gov; or fax the 632 or 632W form only to 1-770-302-8169. After 4/1/12 any documents faxed to the PE Corrections email box other than the 632 or 632W forms will not be acted upon.

Please distribute to all State Office Staff, supervisors and members of the QP team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson, Family Medicaid Program Consultant, at 404-463-0521.

cc: Jon Anderson, DCH Deputy Chief, Member Services & Policy
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, DHS/DFCS Director Right from the Start Medicaid
Sophia Jefferies, Program Consultant, Department of Public Health
Cathy Broom, Program Consultant, Department of Public Health
Lynnette Rhodes, DCH Legal Services
HP File



MEMORANDUM

TO: Dr. Seema Csukas, Interim Program Director
Maternal and Child Health and WIC Programs
Department of Public Health
FROM: Yvonne Greene, Eligibility Program Director 2
Medicaid Eligibility Policy (DCH)
DATE: January 31, 2013
SUBJECT: Increase in Income Levels for Presumptive Eligibility (PE) Medicaid

The poverty level income limits used to determine Presumptive Eligibility Medicaid have changed. Income limits are based on the federal poverty guidelines that are revised and published annually. These new income limits should be used for all Presumptive Eligibility determinations completed by the Department of Public Health, beginning February 1, 2013.

Table with 2 columns: Family Size and Monthly Income Limit. Rows for family sizes 1 through 8 with corresponding income limits.

EACH ADDITIONAL PERSON ADD: \$670

Please distribute to all State Office Staff, supervisors and members of the DPH team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson, mwilson@dch.ga.gov, at 404-463-0521.

- cc: Jon Anderson, Deputy Chief, Member Services & Policy
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, Director, DHS Right from the Start Medicaid
Sophia Jefferies, Program Consultant, Division of Public Health
Cathy Broom, Program Consultant, Division of Public Health
Lynnette Rhodes, DCH Legal Services
Federally Qualified Health Centers/Rural Health Centers



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

December 23, 2013

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

FROM: Yvonne Greene, Eligibility Program Director 2
Medicaid Eligibility Policy (DCH)

RE: Affordable Care Act Changes for Presumptive Eligibility Medicaid

The purpose of this Memorandum is to inform Qualified Providers (QP) of the Affordable Care Act (ACA) changes to the Presumptive Eligibility (PE) Medicaid effective January 1, 2014.

FEDERAL POVERTY LEVEL (FPL)

For PE Pregnancy Medicaid and PE Women’s Health Medicaid (WHM) the FPL will increase from 200% to 220%. The Centers for Medicare and Medicaid Services (CMS) provided clarification on how to calculate the 5% FPL deduction amount, disregard any previous income charts that were distributed.

Family Size	PGW		5% Disregard amount	Family Size	PGW		5% Disregard amount
	220%	Plus 5%			220%	Plus 5%	
1	\$2,108	\$2,156	\$48	11	\$9,478	\$9,694	\$216
2	\$2,845	\$2,910	\$65	12	\$10,215	\$10,448	\$233
3	\$3,582	\$3,664	\$82	13	\$10,952	\$11,201	\$249
4	\$4,319	\$4,418	\$99	14	\$11,689	\$11,955	\$266
5	\$5,056	\$5,171	\$115	15	\$12,426	\$12,709	\$283
6	\$5,793	\$5,925	\$132	16	\$13,163	\$13,463	\$300
7	\$6,530	\$6,679	\$149	17	\$13,900	\$14,216	\$316
8	\$7,267	\$7,433	\$166	18	\$14,637	\$14,970	\$333
9	\$8,004	\$8,185	\$182	19	\$15,374	\$15,724	\$350
10	\$8,741	\$8,939	\$199	20	\$16,111	\$16,478	\$367



Dr. Seema Csukas
Affordable Care Act Changes for Presumptive Eligibility Medicaid
Page 2 of 3

FORMS

The PE application forms 632 (PE Pregnancy) and 632W (PE WHM) have been revised.

The single streamlined application will be used as the full Medicaid application for PE Pregnancy Medicaid. The current full Medicaid application form 94 will continue to be used for PE WHM.

The HIPAA form 5460 was revised and should be used when the Division of Family and Children Services (DFCS), or the Right from the Start (RSM) Project, is able to supply QPs the revised form. Only the signature page four (4) will need to be included in the PE Packets. The current HIPAA form 5460 can be used until the revised form has been supplied, or QPs in house HIPAA form can be used temporarily so the cost of copies is not incurred.

DCH has requested all original versions of the HIPAA form 5460 from DFCS' central supply be delivered to the local DPH offices as these forms are still valid until supplies have been depleted.

Copies of these forms are attached to this Memorandum and are included in the PE manuals on line for January 1, 2014.

ACA CHANGE FOR PE MEDICAID

The PE Pregnancy Medicaid determination process will change significantly due to the ACA. These changes are included in the updated PE ACA Pregnancy Manual available January 1, 2014 on the Georgia Medicaid Management Information System (GAMMIS) Web Portal. DCH completed introduction training on these changes in October 2013.

PE WHM Medicaid will only have the FPL change and updated form 632W; no other changes will occur. PE WHM changes are included in the updated PE ACA WHM Manual available January 1, 2014 on the GAMMIS Web Portal.

QP workers that complete both PE Pregnancy and PE WHM Medicaid must be cautious of the differences in determining PE Medicaid beginning January 1, 2014.

PE TRAINING

Due to changes with the VICs scheduling, PE Pregnancy and PE WHM training dates will be still be conducted quarterly; however, the dates will be different and announced once DCH receives the confirmation of the new dates for 2014.



Dr. Seema Csukas
Affordable Care Act Changes for Presumptive Eligibility Medicaid
Page 3 of 3

PREGNANCY CORRECTIONS

Changes with the ACA require PE Pregnancy Medicaid to accept the applicant's statement of pregnancy and the number of expected births. Medical verification is not allowed prior to the PE Pregnancy approval. If the applicant is approved for PE Pregnancy Medicaid and it is discovered afterwards that she is not pregnant, this case must be reported to DCH immediately for closure.

Email Memi Wilson at mwilson@dch.ga.gov with the subject line indicating PE closure. The email will contain the beneficiary's name and member ID number to be closed; or fax the 632 form indicating on the form she is not pregnant to 770-344-4232.

QUALIFIED HOSPITALS

The ACA requires that Qualified Hospitals (QH) have the option to complete PE Medicaid for Pregnancy, WHM, Parent/Caretaker with Child(ren), Children Under 19 Years of Age, and Former FosterCare Medicaid. Successful completion of PE training is required for QHs making PE determinations.

CMS must approve the PE Hospital Manual and updates to GAMMIS must be completed prior to allowing QHs to complete PE Medicaid applications.

PE training will be completed quarterly at DCH. The first training is scheduled February 5, 2014 with additional training offered the first Wednesday in April, July and October; WebEx training and onsite training will also be available.

ATTACHMENTS

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Jonathan Duttweiler, Medicaid Policy Unit Manager, DFCS Office of Family Independence
Judy Adan, Interim RSM Project Director
Tara Dickerson, DCH Legal Services Director
Wesley Merritt, DCH QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara E. Crane, Director, Office of Cancer Screening and Treatment, DPH
Cathy Broom, Program Consultant, DPH
Barbara Vance, Myers and Stauffer



January 14, 2014

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

FROM: Yvonne Greene, Eligibility Program Director 2 *Yvonne Greene*
Medicaid Eligibility Policy (DCH)

RE: Presumptive Eligibility Medicaid Training

The purpose of this Memorandum is to inform Qualified Providers (QP) and Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Training dates for 2014 and also to provide information about the additional page on PE Medicaid applications to add budget group members.

PE PREGNANCY MEDICAID

Quarterly VICs PE Pregnancy Medicaid training is scheduled to begin at 9:00 AM and end at 3:00 PM on the dates and at the locations listed below. Lunch is planned for 12:00 PM to 1:00 PM.

- February 26th (10th floor)
- May 28th (16th floor)
- August 27th (16th floor)
- November 26th (16th floor)
- January 23rd has been scheduled as a specialized training for PE Pregnancy Budget Groups training (16th floor).

PE WOMEN'S HEALTH MEDICAID (WHM)

Quarterly VICs PE WHM training is scheduled to begin at 9:00 AM and end at 3:00 PM on the dates and at the locations listed below. Lunch is planned for 12:00 PM to 1:00 PM.

- February 20th (10th floor)
- May 15th (16th floor)
- August 21st (16th floor)
- November 20th (16th floor)



Dr. Seema Csukas
Presumptive Eligibility Medicaid Training
Page 2 of 3

PE HOSPITAL MEDICAID TRAINING

Quarterly PE Hospital Medicaid training is scheduled to begin at 9:00 AM and end at 3:00 PM. Lunch is planned for 12:00 PM to 1:00 PM. Training will take place on the dates listed below in the Department of Community Health, 5th floor Overflow room. DCH is located at #2 Peachtree Street, Atlanta Georgia 30303.

- February 5th
- April 2nd
- July 2nd
- October 1st

FORMS

A second page has been created for Qualified Providers and Qualified Hospitals to add budget group members if additional lines are needed. This second page can be used for PE Medicaid application forms 632 PE Pregnancy Medicaid, 632W PE WHM and 632H Qualified Hospital Presumptive Eligibility Determination.

When page two is used it will be included in the PE Packet. All PE Pregnancy Packets will continue to be given to the Right from the Start Medicaid (RSM) Project or the Division of Family and Children Services (DFCS) office; all PE WHM Packets will continue to be faxed to ARROWHEAD daily; all PE Hospital Packets will be faxed to DCH daily.

ATTACHMENT

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Jonathan Duttweiler, Medicaid Policy Unit Manager, DFCS Office of Family Independence
Judy Adan, Interim RSM Project Director
Tara Dickerson, DCH Legal Services Director
Wesley Merritt, DCH QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara E. Crane, Director, Office of Cancer Screening and Treatment, DPH
Cathy Broom, Program Consultant, DPH
Paula Brown, Project Officer, DPH
Barbara Vance, Myers and Stauffer



April 7, 2014

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health
FROM: Yvonne Greene, Eligibility Program Director 2
Medicaid Eligibility Policy (DCH)
RE: Presumptive Eligibility Medicaid Federal Poverty Levels and Forms

The purpose of this Memorandum is to inform Qualified Providers (QP) and Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2014 and to provide the revised PE forms.

FEDERAL POVERTY LEVEL (FPL)

As a result of the Affordable Care Act (ACA) the Centers for Medicare and Medicaid Services (CMS) increased the FPL for PE Pregnant Women Medicaid from 200% to 220% effective January 1, 2014. This year, Georgia will implement the annual cost of living increase effective April 1, 2014.

PE Pregnant Women Medicaid 220% FPL Effective 4/1/14

Table with 8 columns: Budget, 220%, 5%, 220%, Budget, 220%, 5%, 220%. Rows 1-10 showing FPL, Deduction, and Plus 5% values for various groups.

Add \$746 to the net income limit, and \$17 to the deduction, for any additional individual(s) added.



Dr. Seema Csukas
Presumptive Eligibility Medicaid Federal Poverty Levels and Forms
Page 2 of 4

The FPL for PE Women’s Health Medicaid (WHM) remained 200% effective January 1, 2014 through March 31, 2014. This year Georgia will implement the annual cost of living increase effective April 1, 2014.

PE Women’s Health Medicaid 200% FPL Effective 4/1/14

Budget Group	200% FPL	Budget Group	200% FPL
1	1946	11	8716
2	2622	12	9394
3	3300	13	10072
4	3976	14	10750
5	4652	15	11428
6	5330	16	12106
7	6006	17	12784
8	6682	18	13462
9	7360	19	14140
10	8038	20	14818

Add \$678 to the net income limit for any additional individual(s) added.

FORMS

The PE Medicaid forms have been updated as fillable PDF forms. Instructions for completion are located in each PE Medicaid manuals.

- DMA 632 PE Pregnant Women Medicaid Application
- DMA 632/632H PE Medicaid Page 2
- DMA 632W PE Women’s Health Medicaid Application
- DMA 632W PE WHM Page 2
- DMA 634 Approval Notice of Action for PE Pregnant Women Medicaid
- DMA 634 Denial Notice of Action for PE Pregnant Women Medicaid
- DMA 634W Approval Notice of Action for PE WHM
- DMA 634W Denial Notice of Action for PE WHM

Page two (2) of DMA 632/632H and DMA 632W is used when more space is needed for additional household members and should be included in the PE Packet when used. All PE Pregnancy Packets will continue to be given to the Right from the Start Medicaid (RSM) Project or the Division of Family and Children Services (DFCS) office; all PE WHM Packets will continue to be faxed to ARROWHEAD daily; all PE Hospital Packets will be faxed to DCH daily.



Dr. Seema Csukas
Presumptive Eligibility Medicaid Federal Poverty Levels and Forms
Page 3 of 4

The Quick Guide for Women's Health Medicaid and Pregnant Women Medicaid forms have also been updated.

THIRD PARTY LIABILITY (TPL)

A Third Party resource means any individual, entity or program that is or may be liable to pay all or part of the costs for medical assistance furnished under Medicaid.

The Department of Community Health (DCH) requires all Medicaid providers to take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under Medicaid. Medicaid is the secondary payer of claims when a TPL exists and providers should file Medicaid claims accordingly. DCH has developed a process for the Department of Public Health (DPH) to follow should an error code appear for a Medicaid claim after the TPL was billed. DPH should refer to their District Billing Supervisor on the procedures to follow. All other claim issues are to be referred to the DPH's Provider Representative by calling 1-800-766-4456 or using the Contact Us feature on the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov/portal.

A DMA 285 form should be completed after a PE application has been approved, if TPL is discovered either verbally by the beneficiary or the TPL is listed on GAMMIS.

The only requirement for a PE beneficiary is to agree to cooperate with Medicaid regarding their TPL by completing the top part of the DMA 285 form and sign/date both signature sections at the bottom. If the beneficiary indicates they no longer have the TPL listed on GAMMIS, have them complete these same sections and indicate on the DMA 285 "Cancelled".

The beneficiary is not required to provide their insurance card, but if they have it with them the QP/QH should make a photocopy of the front and back of the card. Write the beneficiaries name and Medicaid ID number on the photocopy and include this page with the DMA 285 form to be either mailed (new address) or faxed to:

Health Management System (HMS)
900 Circle 75 Parkway
Suite 650
Atlanta, GA 30339
OR
Fax: 770-937-0180

The DMA 285 form is located in the PE Manuals and on GAMMIS.



Dr. Seema Csukas
Presumptive Eligibility Medicaid Federal Poverty Levels and Forms
Page 4 of 4

PE PREGNANCY CORRECTIONS

Changes with the Affordable Care Act (ACA) require QPs/QHs to accept the applicant's statement of pregnancy and the number of expected births. Medical verification is not allowed prior to the PE Pregnant Women Medicaid approval. If the applicant is approved for PE Pregnant Women Medicaid, and it is medically verified afterwards that she is not pregnant, this case must be reported to DCH immediately for closure.

Email Memi Wilson at mwilson@dch.ga.gov with the subject line indicating PE closure. The email will contain the beneficiary's name, member ID number, and the date of the medical verification the beneficiary is not pregnant. If the PE Pregnant Women Medicaid was approved the same day, fax the PE Pregnant Women Medicaid packet and include a copy of the email to 770-344-4232; DCH will forward the PE packet to the Division of Family and Children Services (DFCS) for immediate action.

PE PREGNANT WOMEN MEDICAID CLOSURES

When a beneficiary's PE Pregnant Women Medicaid case has closed, and the full Medicaid case has not updated, DPH will speak with their Right from the Start Medicaid (RSM) worker to resolve. QPs/QHs are not authorized to complete back-to-back PE applications. The ACA only allows one approved PE Pregnant Women Medicaid per the same pregnancy.

Please distribute to all State Office Staff, supervisors and members of the QP team that process the PE Pregnant Women Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson, mwilson@dch.ga.gov, Family Medicaid Program Consultant, at 404-463-0521.

ATTACHMENTS

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Jonathan Duttweiler, Medicaid Policy Unit Manager, DFCS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, DCH Legal Services Director
Wesley Merritt, DCH QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara E. Crane, Director, Office of Cancer Screening and Treatment, DPH
Cathy Broom, Program Consultant, DPH
Paula Brown, Project Officer, DPH



February 20, 2015

MEMORANDUM

TO: Dr. Seema Csukas, Director Maternal and Child Health Section, Department of Public Health
FROM: Yvonne Greene, Eligibility Program Director 2 DCH Medicaid Eligibility & Policy
RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2015

The purpose of this memorandum is to inform Qualified Providers (QP) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2015. The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2015 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in processing presumptive eligibility effective April 1, 2015.

PE Pregnant Women Medicaid FPL at 220% effective April 1, 2015

Table with 4 columns: Budget, 220%, 5%, 220%. Rows 1-12 showing FPL, Deduction, and Plus 5% values.

Add \$763 to the net income limit, and \$17 to the deduction, for any additional individual(s) added

Page 2
February 20, 2015
Dr. Seema Csukas

Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level. Please use this income limit chart effective April 1, 2015.

Budget Group	200% FPL
1	1962
2	2655
3	3349
4	4042
5	4735
6	5429
7	6122
8	6815
9	7509
10	8202
11	8895
12	9589

Add \$694 to the net income limit for any additional individual(s) added.

Please distribute to all State Office Staff, Supervisors, and members of the QP team that process the PE Pregnant Women Medicaid and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact Karen Y. Houston, Family Medicaid Program Consultant, at 404-657-7270.

cc: Bonnie Taylor, Interim Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director, Medicaid Legal Services
Randall Solomon, Interim Member Enrollment Director
Wesley Merritt, QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



March 4, 2015

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

FROM: Yvonne Greene, Eligibility Program Director 2 *YGS*
Medicaid Eligibility Policy (DCH)

RE: GAMMIS system changes for Presumptive Pregnant Women and Presumptive Women's Health Medicaid

The purpose of this Memorandum is to inform Qualified Providers of the system changes within GAMMIS in reference to the begin date of eligibility for persons who are determined presumptively eligible and changes to the panels implemented on 02/26/15.

Presumptive Eligibility (PE) Start Date

Members determined Presumptively Eligible will have an eligibility start date based on the date the Qualified Provider determines the member eligible for Presumptive Eligibility. The member's eligibility will no longer revert to the first day of the month.

Women's Health Medicaid Panel Changes

- Women's Healthcare Request panel has been changed to Women's Health Medicaid Panel
- Determination/Eligibility Begin date field- This field will replace the Eligibility Begin Date field. The date in this field will represent member's effective date of eligibility. The system will default to the current date. The member's eligibility will no longer revert to the first day of the month.
- Net income -The members calculated net income
- Application date- This is the date the member applied for PE services. This date cannot be more than 30 calendar days in the past or future.
- Medicaid Application submitted Y/N- Select Y or N if the member completed a full Medicaid application.

Pregnant Women Panel Changes:

- Determination/Eligibility Begin date field- This field will replace the Eligibility Begin Date field. The date in this field will represent the member's effective date of eligibility. The system will default to the current date. The member's eligibility will no longer revert to the first day of the month. Application Date- This is the date the member applied for PE services. This date cannot be more than 30 calendar days in the past or future.
- Net taxable income -The member's net taxable income.
- Medicaid Application Submitted Y/N- Select Y or N if the member completed a full Medicaid application.
- Presumptive Pregnant Women will now have the aid category of 864. Aid category 865 will no longer be available; however the member will be eligible to receive the same level of coverage and services.

Please distribute to all State office staff, supervisors, and members of the QP team that process the PE Pregnant Women Medicaid and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact Anika Washington, awashington1@dch.ga.gov, Program Consultant at 404-657-7263.

cc: Jonathan Duttweiler, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Ginger Henry, Interim Medicaid Policy Unit Manager, DFCS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director
Shelia Alexander, PeachCare for Kids® Program Director
Barbara E. Crane, Director, Office of Cancer Screening and Treatment, DPH
Cathy Broom, Program Consultant, DPH
Paula Brown, Project Officer, DPH
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

July 9, 2015

MEMORANDUM

TO: Ginger Henry, Medicaid Policy Unit Manager
DFCS Office of Family Independence

FROM: Yvonne Greene, Eligibility Program Director 2 *YJG*
DCH Medicaid Eligibility & Policy

RE: Same Sex Marriage - How do we treat Income and Resources?

Question:

If we have a same sex married couple, how do we treat income and resources, both if they indicate they file jointly or indicate they file separately. How do we determine who gets included in a Parent/Caretaker with children budget, if income eligible?

Response:

On June 26, 2015, the Supreme Court, in *United States v. Obergefell ET AL. v. Hodges, Director, Ohio Department of Health, ET AL.* held: "The Fourteenth Amendment requires a State to license a marriage between two people of the same sex and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out of state." In addition "The Court, in this decision, holds same-sex couples may exercise the fundamental right to marry in all States. It follows that the Court also must hold – and it now does hold – that there is no lawful basis for a State to refuse to recognize a lawful same-sex marriage performed in another State on the ground of its same-sex character." Governor Deal states Georgia will abide by the Federal law. As of June 26, 2015 Georgia recognizes same sex marriage for the Medicaid and PeachCare for Kids® programs.

For Medicaid Modified Adjusted Gross Income (MAGI), Non-MAGI and PeachCare for Kids® programs the treatment of income and resources will be the same for same sex married couples and married couples of the opposite sex.

Please note we do not count resources in MAGI.

Ginger Henry
Page 2
July 9, 2015

Please update the Office of Family Independence Medicaid procedures manual to reflect this change throughout. Also, issue a numbered bulletin to expedite the dissemination of this information. If you have any questions or need additional information please contact Karen Y. Houston at 404-657-7270.

cc: Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director of Medicaid Legal Services
Wesley Merritt, QC Program Director 2
Randall Solomon, Interim Member Enrollment Director
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



MEMORANDUM

TO: Carrie Summers, VP, Healthcare Financing
Georgia Hospital Association
FROM: Yvonne Greene, Eligibility Program Director 2
DCH Medicaid Eligibility & Policy
RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2016
DATE: March 11, 2016

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2016. The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2016 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in processing presumptive eligibility effective April 1, 2016.

Table with 12 rows (Budget Group 1-12) and 17 columns (Parent/Caretaker with Children, Children 6-18, Children 1-5, Children 0-1, Pregnant Women, PCK, P40B). Columns include FPL, Deductions, Plus 5%, 100%, Plus 5%, 205%, Plus 5%, 220%, Plus 5%, 247%, Plus 5%, 200%, Plus 5%.

Carrie Summers
Page 2
March 11, 2016

Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level. Please use this income limit chart effective April 1, 2016.

Budget	200%
Group	FPL
1	1980
2	2670
3	3360
4	4050
5	4740
6	5430
7	6122
8	6816
9	7510
10	8202
11	8896
12	9590

Add \$694 to the net income limit for any additional individual(s) added.

Please distribute to all Hospital Staff, Supervisors, and members of the QH team that process the PE Pregnant Women Medicaid, PE Parent/Caretaker with Children Medicaid, Children under 19 Medicaid, and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact, Gloria D. Hill, Healthcare Program Consultant 3, at 404-463-0521, cell 470-259-8609 or ghill1@dch.ga.gov.

cc: Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Medical Assistance Group Director
Tara Dickerson, Deputy General Counsel
Randall Solomon, Member Enrollment Director
Wesley Merritt, QC Program Director 2
Sheila Alexander PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

August 21, 2014

MEMORANDUM

TO: Jonathan Dutweiler, Medicaid Policy Unit Manager
DFCS Office of Family Independence

FROM: Yvonne Greene, Eligibility Program Director 2 
DCH Medicaid Eligibility & Policy

RE: Social Security Retirement, Survivor's, Disability Insurance (RSDI) Income of Tax Dependents for Modified Adjusted Gross Income (MAGI) based Medicaid and PeachCare for Kids® determinations.

BACKGROUND

The Patient Protection and Affordable Care Act of 2010 required the use of new financial methodologies when determining Medicaid eligibility for MAGI classes of assistance. This methodology redefines the financial household by utilizing the tax filing status of an applicant or beneficiary. The household composition rules are applied to classes of assistance that are required to use MAGI methodology to determine household taxable income and eligibility

PURPOSE

To provide additional clarification on Social Security RSDI received by a tax dependent child for MAGI based budgeting based on the Affordable Care Act (ACA) effective January 1, 2014.

If the tax dependent/child has no other source of income and resides with a parent (biological, step, adopted), the Social Security RSDI income is excluded. RSDI of a tax dependent/child is countable only if the tax dependent/child has OTHER income that meets the IRS tax filing threshold for tax dependents or if the child does not reside with a parent and is not claimed as a tax dependent by his or her parent.

Jonathan Duttweiler
Page 2
August 21, 2014

Note: The filing threshold is applied based on whether the individual should file a tax return. If the individual does not file, the threshold still applies.

The current (2013) IRS tax filing thresholds for tax dependents are:

- \$6100 annually for EARNED income
- \$1000 annually for UNEARNED income

Note: RSDI does NOT count toward the unearned threshold.

Note: The 2014 IRS tax filing thresholds will begin in January 2015.

Please update the Office of Family Independence Medicaid procedures manual to reflect this clarification. Also, issue a numbered bulletin to expedite the dissemination of this information. If you have any questions or need additional information please contact Karen Y. Houston at khouston@dch.ga.gov or 404-657-7270 or Mollie Elder at melder@dch.ga.gov or 404-463-8369.

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, DCH Legal Services, Director
Wesley Merritt, QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer

Appendix R -Resources

Medicaid Transportation:

Non-Emergency Transportation

Beneficiaries enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid beneficiaries to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid member and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Department of Community Health (DCH) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the HP Member Contact Center at 866-211-0950.**

Please give PE beneficiaries a copy of the following page regarding NET.



Non-Emergency Transportation

Effective on and after July 1, 2012, the following Non-Emergency Transportation (NET) Brokers will coordinate transportation for Medicaid members who have no other way to get to medical care or services covered by Medicaid. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday – Friday) from 7 a.m. to 6 p.m. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly.

If you need NET services, you must contact the NET Broker servicing the county you live in to ask for non-emergency transportation. Please see the chart below to determine which broker services your county and call the broker's telephone number for that region.

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

The Division of Medicaid monitors the quality of the services brokers provide. If you have questions or comments about a NET Broker, contact HP Enterprise Services Contact Center at 866-211-0950.

PowerLine:

The PowerLine is a statewide toll-free telephone number that provides healthcare referrals.

The PowerLine is managed by Healthy Mothers, Healthy Babies Coalition of Georgia. It was established in 1984 as a means of directing pregnant women to prenatal services.

PowerLine's mission was expanded in 1989 via a contract with the Georgia Department of Community Health to assist women and children in accessing Medicaid providers and public health programs.

Today, PowerLine provides healthcare referrals to any Medicaid, PeachCare for Kids® and uninsured Georgian.

PowerLine can assist both English and Spanish speaking customers in gaining accesses services.

The PowerLine maintains a database of Georgia's Medicaid and PeachCare for Kids® accepting providers. For those not eligible for Medicaid or PeachCare for Kids®, referrals are made to healthcare providers who offer low-cost or sliding scale fee services.

To access the PowerLine, call 1-800-822-2539 or, in the metro Atlanta area, 770-451-5501 from 8:00 AM to 6:00 PM, Monday through Friday.

More information may be obtained at the following web site:

<http://www.hmhbga.org/index.php>

You can order free material to hand out to applicants by going to:

http://www.hmhbga.org/index.php?option=com_netinvoice&action=orders&ask=order&cid=2&Itemid=88

Materials Order Form

Healthy Mothers, Healthy Babies Coalition of Georgia offers FREE materials on PowerLine. Please submit your order below:



P O W E R L I N E

The Healthy Mothers, Healthy Babies PowerLine is your source for statewide healthcare referrals and information

**Metro Atlanta 770-451-5501
Statewide 800-822-2539
Monday through Friday
8:00AM-6:00PM**

PowerLine is a fast way to find exactly the care you need.

PowerLine is a free service, funded by the Division of Public Health of the Georgia Department of Community Health.

One simple call puts you in contact with:

- ◆ Medicaid Doctors
- ◆ Dental Referrals
- ◆ Low-Cost Health Resources for the Uninsured
- ◆ WIC, Children 1st and Babies Born Healthy
- ◆ Low-Cost Prenatal Referrals
- ◆ Other Public Health Programs
- ◆ Referrals for Breastfeeding Questions
- ◆ Referrals to HIV Testing

PowerLine es una forma rápida de encontrar el cuidado que usted necesita. Una llamada le pone en contacto con:

- ◆ Referencias a Médicos
- ◆ Directorio de cuidado prenatal de bajo costo
- ◆ WIC, Children 1st, y sitios para pruebas de VIH
- ◆ Apoyo para Lactancia

Text4baby:



United States Department of Agriculture

Research, Education, and Economics
Agricultural Research Service
National Agricultural Library

SUBJECT: Summer WIC Mailing
TO: Regional, State and Local WIC Offices
FROM: Debra Whitford
Director, Supplemental Food Programs Division
Food and Nutrition Service

Shirley King Evans
Acting Coordinator
Food and Nutrition Information Center
National Agricultural Library

The WIC Program is pleased to be a partner in the Text4baby initiative, which aims to address the national health challenge of improving maternal and child health. Text4baby is a mobile information service designed to provide free, health-related text messages to underserved pregnant women and new mothers, empowering them with information they need to ensure their health and give their babies a healthy start in life. Women who sign up for the service by texting BABY (or BEBE for Spanish) to 511411 will receive free SMS text messages each week, timed to their due date or baby's date of birth.

This initiative is made possible through a public-private collaboration among government and tribal agencies, corporations, non-profit organizations, professional associations, and academic institutions. Led by the National Healthy Mothers and Healthy Babies Coalition, the goal of the Text4baby initiative is to launch and evaluate the effectiveness of mobile health technology as a means of providing critical health information and promoting positive health outcomes among underserved populations.

Enclosed in this mailing are four, 8 x 10 inch sample posters promoting the Text4Baby initiative. Each of the four posters features a pregnant woman from a different racial/ethnic group and one poster is available in Spanish. These files are available to print from the WIC Works Web site <http://wicworks.nal.usda.gov>. An order form is included if you would like to obtain additional Text4baby materials, including full-size, 18 x 24 inch posters and tear-pads. Please note that we have limited quantities of these items available. Additionally, WIC agencies are encouraged to become a Text4Baby Outreach Partner to promote the initiative and encourage the families you serve to sign up for the service. As partners, you are eligible to receive several benefits such as artwork for promotional materials, program updates, and access to an online partner portal.

Using modern technology to provide valuable health and nutrition information to expectant and new moms is what WIC is all about. We hope that you will use the enclosed information to promote this new innovative program to your participants. If you would like to learn more about Text4baby or become an Outreach Partner, please visit their Web site www.text4baby.org. Please let us know what else we can do to help you help WIC! Contact the WIC Works team by phone: 301-504-6047, by fax: 301-504-6409, or by email: wicworks@ars.usda.gov.



National Agricultural Library • Public Services Division
10301 Baltimore Avenue • Beltsville, MD 20705-2351

An Equal Opportunity Employer

HEY MOM, It's 4U!



Text **BABY** to **511411**

Get **FREE** tips on your cell phone
to help you through your pregnancy
and your baby's first year.



Powered by **WVXIVK**

Text4baby is a program of the
National Healthy Mothers, Healthy Babies Coalition.
Prenatal activities in Virginia generously supported by



text4baby.org



Be Smart. Plan Before You Start!

Planning for Healthy Babies®

What is the Planning for Healthy Babies program?

Planning for Healthy Babies provides no cost family planning services to eligible women in Georgia. You can enroll in either:

- Family planning
- Resource Mother – provides assistance to women who deliver a baby weighing less than 3 pounds, 5 ounces
- Inter-pregnancy care (IPC) – only for women who deliver a baby weighing less than 3 pounds, 5 ounces, and **includes family planning and Resource Mother services**

What's covered?

- Annual physical exams including pap smears
- Contraceptives and multivitamins with folic acid
- Family planning counseling
- IPC services including primary care and dental services, substance treatment services, Resource Mother services and more

Who is eligible?

- Women ages 18 through 44 who meet monthly family income limits
- Women who **do not** receive Medicaid are eligible for family planning services
- Women who deliver a baby weighing less than 3 pounds, 5 ounces and **do not** receive Medicaid or are losing Medicaid coverage, are eligible for IPC services
- Women who receive Medicaid and deliver a baby weighing less than 3 pounds, 5 ounces are **only** eligible for Resource Mother services

See the other side to apply for Planning for Healthy Babies...



Be Smart. Plan Before You Start!

Planning for Healthy Babies®

How do I apply?

You can apply online at: www.planning4healthybabies.org.

If you are unable to apply online, applications may be picked up at your local:

- Public health department
- Division of Family and Children Services (DFCS) office

Completed applications and required documents should be faxed to **888-744-2102** or mailed to:

Planning for Healthy Babies
Post Office Box 1810
Atlanta, GA 30301-1810

Where can I go for more information?

For more information, visit dch.georgia.gov/p4hb or call **877-P4H-B101** or **877-744-2101**.



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For more information call 877-P4H-8101 (877-744-2101).



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- Division of Family and Children Services

Pick up a post card today!



Planning for
Healthy Babies®



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

How To Order Understanding Medicaid Booklets

For all Public Health (PH), Division of Family and Children
Services (DFCS), Right from the Start Medicaid (RSM), and
Qualified Providers (QP).
2011



Memi Wilson, DCH Family Medicaid Program Consultant 404-463-0521



Web Access

- Go To:

<https://www.mmis.georgia.gov>

Member Information tab and then to the Member
Notification tab.



Member Information Tab:

The screenshot shows the Georgia Department of Community Health Web Portal. The header includes the logo, "GEORGIA DEPARTMENT OF COMMUNITY HEALTH", "GEORGIA WEB PORTAL", and "HEALTH PARTNERSHIP". A search bar is located in the top right. Below the header, a navigation menu includes "Home", "Member Notices", "Find a Provider", "FAQ for Members", and "Register for Secure Access". The "Member Notices" tab is selected. The main content area features a "User Information" section with a "Login/Manage Account" link and a "Login" button. Below this, there are two informational boxes: "PDF Reader Required" with a note about Adobe Acrobat Reader, and "File Download Issues" with advice on browser settings. A table titled "Member Notices (5 rows returned)" lists documents with their titles, sizes, and release dates.

Title	Size (KB)	Release Date
Health Check Brochure	1090.30	10/28/2010
Certification of Medicaid Eligibility	78	10/27/2010
Home and Community Services Booklet	8888.70	10/27/2010
Authorized Representative Form	130.40	11/05/2010
Understanding Medicaid Booklet	972.90	02/21/2011

Web Print

- You may print the booklet from the web. PDF file.

Direct Link:

<https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/MEMBER%20NOTICES/UnderstandingMedicaid.pdf>



Contact Us

- You can use the "Contact Us" feature on the web:

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Home | **Contact Us** | Phone Numbers & Links

User Information ? ✕

Login/Manage Account

Requests Requiring PHI

NOTE: If the response to your inquiry contains protected health information (PHI) such as member or claims information, you must log into the secure web portal to submit your question and receive the response. Upon login, additional contact options related to PHI will be available.

Contact Information ? ✕

How can we help you?

Select an Item*

Enter Category Details

How do you want to be contacted?

Contact Method* Telephone

Last Name, First Name

Phone Number, Ext

DMA 292 (Request for Forms)

- Download form DMA 292 from the web:

Home | Contact Information | Member Information | **Provider Information** | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Home | Provider Notices | Provider Manuals | Provider Messages | Fee Schedules | **Forms** | PASRR Request | TPL Carriers | FAQ for Providers

Web Portal Training | Provider Education

User Information ? ✕

Login/Manage Account

PDF Reader Required

NOTE: If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. [click here to obtain the latest version of the free Adobe Reader.](#)

File Download Issues

Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. [Click here for help with download issues.](#)

ALL FORMS

Forms (57 rows returned)			
Title	Category	Size (KB)	Release Date
DMA-632: Elig. Determination for Pregnancy Related Care	ALL FORMS	23.80	01/10/2011
WV Submittal Form	ENROLLMENT	388.20	01/10/2011
Form 5459 - Member's Release of Information	ALL FORMS	32.60	02/03/2011
Interim Provider Payment Request Form	CLAIMS	31.90	02/03/2011
Medicaid-PreachCare for Kids Provider Information Change Form	ENROLLMENT	36.50	02/10/2011
DMA-292: Request for Forms or Handbooks	ALL FORMS	78.40	03/01/2011

Ordering, Prescribing, and Referring

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA																																																																																									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S ID. NUMBER (For Program in Item 1)																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE					SEX					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																															
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED										7. INSURED'S ADDRESS (No., Street)																																																																															
CITY										STATE										CITY										STATE																																																																					
ZIP CODE										TELEPHONE (Include Area Code)										ZIP CODE										TELEPHONE (Include Area Code)																																																																					
8. RESERVED FOR NUCC USE										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																					
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous)										a. INSURED'S DATE OF BIRTH										SEX																																																																					
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT?										b. OTHER CLAIM ID (Designated by NUCC)										b. OTHER CLAIM ID (Designated by NUCC)																																																																					
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT?										c. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																					
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																																																																					
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p>																				<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p>																																																																															
SIGNED										DATE										SIGNED										DATE																																																																					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)										15. OTHER DATE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																																																																					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI										17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																																																											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?										20. OUTSIDE LAB?										20. OUTSIDE LAB?																																																																					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY																																																																					
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. ICD-9-CM										I. ID. QUAL.										J. REFERRING PROVIDER ID. #									
1										2										3										4										5										6										7										8										9										10									
25. FEDERAL TAX ID. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT?										28. TOTAL CHARGE										29. AMOUNT PAID										30. Rsvd for NUCC Use																																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #										33. BILLING PROVIDER INFO & PH #										33. BILLING PROVIDER INFO & PH #																																																											
SIGNED										DATE										a. NPI										b. NPI										a. NPI										b. NPI																																																	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

- o The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added “(NUCC)” after “APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE.”
Header	Replaced “08/05” with “02/12”
Item Number 1	Changed “TRICARE CHAMPUS” to “TRICARE” and changed” (Sponsor’s SSN)” to “(ID#/DoD#).”
Item Number 1	Changed “(SSN or ID)” to “(ID#)” under “GROUP HEALTH PLAN”
Item Number 1	Changed “(SSN)” to “(ID#)” under “FECA BLK LUNG.”
Item Number 1	Changed “(ID)” to “(ID#)” under “OTHER.”
Item Number 8	Deleted “PATIENT STATUS” and content of field. Changed title to “RESERVED FOR NUCC USE.”
Item Number 9b	Deleted “OTHER INSURED’s DATE OF BIRTH, SEX.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 9c	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 10d	Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).” Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC. FOR DCH/HP: FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “OTHER CLAIM ID (Designated by NUCC). Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed “If yes, return to and complete Item 9 a-d” to “If yes, complete items 9, 9a, and 9d.” (Is there another Health Benefit Plan?)
Item Number 14	Changed title to “DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP).” Removed the arrow and text in the right-hand side of the field. Added “QUAL.” with a dotted line to accommodate a 3-byte qualifier.” FOR DCH/HP: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).
Item Number 15	Changed title from “IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE” to “OTHER DATE.” Added “QUALIFIER.” with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date]); 091 (Report End [Relinquished Care Date]); 444 (First Visit or Consultation).

Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – Used by Medicare for identifiers for provider roles: Ordering, Referring and Supervising. FOR DCH/HP: Use the following Ordering Provider, Referring, Supervising Qualifiers (effective 4/01/2014): Ordering = DK; Referring = DN or Supervising = DQ.
Item Number 19	Changed title from “ RESERVED FOR LOCAL USE ” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).” FOR DCH/HP: Remove the Health Check logic from field 19 and add it in field 24H.
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from “(Relate Items 1, 2, 3 or 4 to Item 24E by Line)” to “Relate A-L to service line below (24E).”
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added “ICD Indicator.” and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. Diagnosis Code ICD Indicator - new logic to validate acceptable values (0, 9) . ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. (Do not bill ICD 10 code sets before January 1, 2016.)
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.” The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F FOR DCH/HP: Item numbers 24A & 24G are used to capture Hemophilia drug units. 24H (EPSDT/Family Planning).
Item Number 30	Deleted “BALANCED DUE.” Changed title to “ RESERVED FOR NUCC USE. ”
Footer	Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”