



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

# Phase II Training

## Hospital Presumptive Eligibility



Presentation to: Qualified Hospitals that complete Presumptive Eligibility (PE) Medicaid Applications

Presented by: Gloria Hill

Date: April 2015



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

# Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

*We are dedicated to A Healthy Georgia.*



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

# PHASE II HOSPITAL PRESUMPTIVE ELIGIBILITY TRAINING FOR POLICIES & PROCEDURES

2015

# AGENDA

- Presumptive Eligibility (PE) Defined by Law and PE Definition
- Qualified Hospital (QH) Requirements & Responsibilities
- General Program Procedures
- Eligibility Program Requirements
- QH Procedural Requirements
- PE Determination By Category
- GAMMIS Online Procedures
- QH Performance Standards
- Necessary Information
- Assessment

# §435.1110 Presumptive Eligibility (PE) Defined

Per the Affordable Care Act (ACA), hospitals who meet the requirements of participation will be given the opportunity to become Qualified Hospitals (QH) by completing PE Medicaid training.

**A QH is a hospital that:**

- Participates as a Georgia Medicaid Provider;
- Notifies DCH of its election to make PE determinations;
- Agrees to make PE determinations consistent with DCH's policies and procedures;
- Assists individuals in completing and submitting the full Medicaid Healthcare Coverage application and understanding any documentation requirements; and
- Has not been disqualified by DCH.



# Definition and Description of PE

- PE is an expedited process of enrolling eligible Georgia residents into the Medicaid program determined by a QH
- Eligibility is based on an individual's taxable income, tax filer status, household size, citizenship/immigration status, and residency.
- The PE period begins on the approved application date, and ends when RSM/DFCS determines eligibility or ineligibility for Medicaid, but no later than at the end of the month following the month of the PE approval



# QH Presumptive Eligibility

## QH Responsibilities for PE applications



# QH Requirements & Responsibilities for PE applications

- **Application to HP request PE access**
- **Memorandum of Understanding agreement**
- **List of authorized personnel to complete PE applications**
- **Make correct PE Medicaid determinations**
- **Complete PE Training**; notification of periodic refresher PE training with hospital staff. The training requirement is met by attending a presumptive workshop and satisfactorily completing the training exercises. Upon completion of the training, each hospital certifies that all QH requirements have been met by completing the QH enrollment form.



# QH Requirements & Responsibilities for PE applications

Upon receipt of the enrollment form, the DCH provider enrollment unit will add the QH specialty code to the provider's file and issue an approval notice to the provider showing the effective begin date for performing QH activities.

- PE monitoring and cooperation with Quality Control (DCH)
- PE reports
- Meet Performance Standards
- PE Corrective Action Plans



# §435.1110 Disqualified Hospital

DCH must take action, including, but not limited to, disqualification of a hospital as a qualified hospital if DCH determines that the hospital is not:

1. Making, or is not capable of making, PE determinations in accordance with applicable DCH policies and procedures; or
2. Meeting the DCH standard.
3. DCH may disqualify a hospital as a qualified hospital after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.



# GENERAL PROGRAM REQUIREMENTS

- PE Medicaid Categories
- Federal Regulations on Time Period
- GAMMIS
- Application & Forms for Enrollment
- PE Criteria on Verification



# Presumptive Eligibility Medicaid Categories

- §435.110 Parent/Caretaker with Child(ren)
- §435.150 Former Foster Care Medicaid
- §435.1102 Children Under 19 years of Age
- §435.1103 Pregnant Women

**(Only the above categories can be completed by QH at this time )**

- §435.213 Women's Health Medicaid  
(Breast and/or Cervical Cancer)

# Federal Regulations on Time Period

	Name of limitation	Description	
<b>+</b>	Pregnant Women/because a woman can potentially have a miscarriage and conceive again before the end of 12 months.	Pregnant women may receive presumptive eligibility, once per pregnancy.	<b>X</b>
<b>+</b>	Infants and Children under age 19, Parents and Other Caretaker Relatives, Former Foster Care Children, and Women's Health (BCC)	Infants and Children under age 19, Parents and Other Caretaker Relatives, Former Foster Care Children, and Women's Health (BCC) may receive presumptive eligibility no more than one period within two calendar years.	<b>X</b>



# GAMMIS-

## Georgia Medicaid Management Information Systems

- Screening on GAMMIS is the first step before the start of a PE Medicaid application.
- If an applicant is on Full Medicaid, **DO NOT** do a PE Medicaid application.
- Exception Planning for Healthy Babies(P4HB) or QMB. (if the beneficiary is active P4HB or QMB complete the PE Medicaid application and GAMMIS will update the system.)

Note: If there is a pending Medicaid application, you can take a Presumptive application.

# Application & Forms for Enrollment

<b>Form Number</b>	<b>Form Name</b>
<b>94a</b>	<b>Single Streamlined Medicaid Application</b>
<b>94a SP</b>	<b>Spanish Single Streamlined Medicaid Application</b>
<b>216</b>	<b>ENGLISH DECLARATION OF CITIZENSHIP</b>
<b>216SP</b>	<b>SPANISH DECLARATION OF CITIZENSHIP</b>
<b>DMA 632H</b>	<b>PE WHM APPLICATION</b>
<b>DMA 634H</b>	<b>Approval NOTICE OF ACTION</b>
<b>DMA 634H</b>	<b>Denial NOTICE OF ACTION</b>
<b>216</b>	<b>ENGLISH DECLARATION OF CITIZENSHIP</b>
<b>216SP</b>	<b>SPANISH DECLARATION OF CITIZENSHIP</b>
<b>5460</b>	<b>ENGLISH HIPAA</b>
<b>5460SP</b>	<b>SPANISH HIPAA</b>
	<b>PE Corrections Cover Sheet</b>
	<b>QUICK GUIDE ON PE MEDICAID</b>
<b>DMA 285</b>	<b>Third Party Liability</b>



# PE Criteria on Verification

- Individual cannot be required to provide proof/documentation of any PE eligibility Criteria  
*(e.g., can't require medical verification of pregnancy)*
- Hospital must accept self-attestation of income, citizenship/ immigration status and residency



# QH PE REQUIREMENTS

## ELIGIBILITY REQUIREMENTS



# Non Financial Eligibility Requirements

- Declaration of Citizenship/Immigration Status  
(applicant's statement is acceptable) \*
- Georgia Resident
- The appropriate age
- A former Foster Care Child up to age 26

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

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



# Budget Group (non-Financial Req's)

- All household members will not necessarily be members of the budget group.
- To be included in the budget group, there must be a tax filer or non tax filer relationship, which is used to determine which individuals must be included in the budget group.
- The budget group is comprised of those members of the household whose needs and net taxable income are included.
- The budget group size determines the income limit used and net taxable income used, then compare to the income standard chart.
- Taxable Income only is used to determine financial eligibility. MAGI budgeting is based on IRS regulations.



# Financial Eligibility Requirements

## Taxable Income

Earned income is the gross income compensation received in exchange for services rendered. It may be in the form of wages, salaries, commissions, or self-employment.

(Self-employment is different. The Net taxable gross income is minus business expenses, that are allowable IRS deductions.)

Only taxable net income is used in the PE Medicaid budgets. Taxable net income is taxable gross minus allowable deductions.

- There are 3 allowable deductions:
  - ~ Pre tax deductions
  - ~ Form 1040 deductions
  - ~ 5% FPL deductions



# Financial Eligibility Requirements

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 to compare to test for PE.

This table shows the conversion factor to use when determining monthly income.



# NON TAXABLE INCOME

**Non Taxable Income:** is excluded in the PE determination based on 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*
- *contributions*
- *Veteran's Benefits*
- *Supplemental Security Income (SSI)*

Income received from these sources is not included in any budget calculations to determine PE Medicaid. A List is provided.

# MAGI (Modified Adjusted Gross Income) Limit for 2015

Income limits for PE Medicaid are based on a percentage of the federal poverty level. The income limit used is determined by the number of people included in the budget group.

MAGI Medicaid Income Limits Table - April 2015

Family Size	100% FPL	5% Deduction	Children 6-18		Children 1-5		Children 0-1/TMA		PGW		PCK		Parent/Caretaker Relative		P4HB	
			133%	Plus 5%	149%	Plus 5%	205%	Plus 5%	220%	Plus 5%	247%	Plus 5%	Limit	Plus 5%	Limit	Plus 5%
1	\$981	\$50	\$1,305	\$1,355	\$1,462	\$1,512	\$2,011	\$2,061	\$2,158	\$2,208	\$2,423	\$2,473	\$310	\$360	\$1,962	\$2,012
2	\$1,328	\$67	\$1,766	\$1,833	\$1,978	\$2,045	\$2,722	\$2,789	\$2,921	\$2,988	\$3,279	\$3,346	\$457	\$524	\$2,655	\$2,722
3	\$1,675	\$84	\$2,227	\$2,311	\$2,495	\$2,579	\$3,433	\$3,517	\$3,684	\$3,768	\$4,136	\$4,220	\$551	\$635	\$3,349	\$3,433
4	\$2,021	\$102	\$2,688	\$2,790	\$3,012	\$3,114	\$4,143	\$4,245	\$4,446	\$4,548	\$4,992	\$5,094	\$653	\$755	\$4,042	\$4,144
5	\$2,368	\$119	\$3,149	\$3,268	\$3,528	\$3,647	\$4,854	\$4,973	\$5,209	\$5,328	\$5,848	\$5,967	\$752	\$871	\$4,735	\$4,854
6	\$2,715	\$136	\$3,610	\$3,746	\$4,045	\$4,181	\$5,565	\$5,701	\$5,972	\$6,108	\$6,704	\$6,840	\$826	\$962	\$5,429	\$5,565
7	\$3,061	\$154	\$4,071	\$4,225	\$4,561	\$4,715	\$6,275	\$6,429	\$6,734	\$6,888	\$7,561	\$7,715	\$903	\$1,057	\$6,122	\$6,276
8	\$3,408	\$171	\$4,532	\$4,703	\$5,078	\$5,249	\$6,986	\$7,157	\$7,497	\$7,668	\$8,417	\$8,588	\$970	\$1,141	\$6,815	\$6,986
9	\$3,755	\$188	\$4,994	\$5,182	\$5,594	\$5,782	\$7,697	\$7,885	\$8,260	\$8,448	\$9,273	\$9,461	\$1,034	\$1,222	\$7,509	\$7,697
10	\$4,101	\$206	\$5,455	\$5,661	\$6,111	\$6,317	\$8,407	\$8,613	\$9,022	\$9,228	\$10,130	\$10,336	\$1,113	\$1,319	\$8,202	\$8,408
11	\$4,448	\$223	\$5,916	\$6,139	\$6,627	\$6,850	\$9,118	\$9,341	\$9,785	\$10,008	\$10,986	\$11,209	\$1,194	\$1,417	\$8,895	\$9,118
12	\$4,795	\$240	\$6,377	\$6,617	\$7,144	\$7,384	\$9,828	\$10,068	\$10,548	\$10,788	\$11,842	\$12,082	\$1,244	\$1,484	\$9,589	\$9,829
13	\$5,141	\$258	\$6,839	\$7,097	\$7,661	\$7,919	\$10,539	\$10,797	\$11,311	\$11,569	\$12,699	\$12,957	\$1,294	\$1,552	\$10,283	\$10,541
14	\$5,488	\$275	\$7,301	\$7,576	\$8,178	\$8,453	\$11,250	\$11,525	\$12,074	\$12,349	\$13,556	\$13,831	\$1,344	\$1,619	\$10,977	\$11,252
15	\$5,835	\$292	\$7,763	\$8,055	\$8,695	\$8,987	\$11,961	\$12,253	\$12,837	\$13,129	\$14,413	\$14,705	\$1,394	\$1,686	\$11,671	\$11,963
16	\$6,181	\$310	\$8,225	\$8,535	\$9,212	\$9,522	\$12,672	\$12,982	\$13,600	\$13,910	\$15,270	\$15,580	\$1,444	\$1,754	\$12,365	\$12,675
17	\$6,528	\$327	\$8,687	\$9,014	\$9,729	\$10,056	\$13,383	\$13,710	\$14,363	\$14,690	\$16,127	\$16,454	\$1,494	\$1,821	\$13,059	\$13,386
18	\$6,875	\$344	\$9,149	\$9,493	\$10,246	\$10,590	\$14,094	\$14,438	\$15,126	\$15,470	\$16,984	\$17,328	\$1,544	\$1,888	\$13,753	\$14,097
19	\$7,221	\$362	\$9,611	\$9,973	\$10,763	\$11,125	\$14,805	\$15,167	\$15,889	\$16,251	\$17,841	\$18,203	\$1,594	\$1,956	\$14,447	\$14,809
20	\$7,568	\$379	\$10,073	\$10,452	\$11,280	\$11,659	\$15,516	\$15,895	\$16,652	\$17,031	\$18,698	\$19,077	\$1,644	\$2,023	\$15,141	\$15,520
21	\$7,915	\$396	\$10,535	\$10,931	\$11,797	\$12,193	\$16,227	\$16,623	\$17,415	\$17,811	\$19,555	\$19,951	\$1,694	\$2,090	\$15,835	\$16,231
Additional Per HH Member	\$346.66		\$462		\$517		\$711		\$763		\$857		\$50		\$694	

# QH Presumptive Eligibility

## Procedural Responsibilities of Qualified Hospitals



# Procedural Responsibilities of Qualified Hospitals

The process involves several steps from the point of application with QH through the final disposition of the applicant's Medicaid application by the RSM/DFCS teams.

1. The QH shall conduct an interview with applicant:
  - Advise they may be eligible for Medicaid benefits as PE beneficiary and for full Medicaid benefits for ongoing and retroactive Medicaid coverage;
  - Obtain enough information to determine income eligibility and establish if the individual(s) is PE eligible and to complete the PE application form 632H, the declaration of citizenship/immigrant status for 216, and the HIPPA form;
  - Determine if the applicant meets the PE Medicaid eligibility criteria;



# Procedural Responsibilities of Qualified Hospitals

2. For any applicant determined **presumptively eligible**, the QH shall:
  - After the PE determination is complete ask if the want a full Medicaid application. If yes, assist the applicant with the single streamed lined application form 94a for ongoing and retroactive Medicaid eligibility at the applicants requests.
  - Perform on-line entry of the application or forward to HP member when a QH does not have internet access to GAMMIS.
  - Provide the applicant with a temporary Medicaid certificate.
  - Inform the applicant of the PE time limit and the services covered;
  - The QH will fax the completed PE application packet to DCH for review within 5 calendar days upon completion of PE determination.

# Procedural Responsibilities of Qualified Hospitals

3. Summarize benefits and answer any questions.
4. Provide the applicant with a copy of the Medicaid Guide and fact sheet “Quick Guide on Medicaid”, which explains the program.
5. Inform the applicant about Planning for Healthy Babies (PH4B)
6. Give the applicant a copy of the Understanding Medicaid Booklet.



# Procedural Responsibilities of Qualified Hospitals

7. Assist the applicant with completing the healthcare coverage application and signature. If the applicant provides proof of identity and/or citizenship, obtain a copy for the healthcare coverage application, write “viewed and copied” on each copy. The only part of the Medicaid healthcare coverage application that is required after the completion of the PE is the applicant’s signature, contact information, signature and date. At this point of the Medicaid healthcare application the applicant can request any prior months.
8. QH to provide the applicant with the address and telephone number of the local RSM/DFCS office.

<https://dch.georgia.gov/rsm-contact-information>



# PE DETERMINATION PROCESS BY CATEGORY

- §435.150 Former Foster Care Medicaid
- §435.110 Parent/Caretaker with Child(ren)
  - §435.1102 Children Under 19 Years of Age
  - §435.1103 Pregnant Women

# How to Determine Eligibility for §435.150 Former Foster Care Medicaid Child

Provides Medicaid coverage for individuals that have aged out of Foster Care at 18 years of age or older.

- Foster Care is not limited in only Georgia
- The individual must be under 26 years of age.
- No income or asset test required.
- They will be the only one included in their budget group. Tax filer/Non Tax Filer status is not considered. If they have other family members, such as a child, these individuals are considered for another type of Medicaid.



# Example of Former Foster Care Child

Lisa Leigh (24 years old) received Foster Care in Washington until she aged out of the program at 18. She now lives in Georgia with her 3 year old child. She will not file a tax return this year. Who is included in the budget group?

For this household we have two different budget groups:

PE Former Foster Care Medicaid will have a budget group of one, Lisa.

PE Children under 19 years of age will have a budget group of two, Lisa and her child.

Same scenario except Lisa earns \$1500.00 a month and will file a tax return.

Lisa will still be eligible because there is no income or asset test for Former Foster Care Child(ren)

her 3 year old child will be eligible base on MAGI income. This is a household of two. 133% is \$2495 . Plus 5% is \$2,311. Her income is \$1500.

They are both eligible for presumptive Medicaid.

# Former Foster Care Child Application

- Basic Demographics
- Tax filing status if so
- Dependents you claim
- Income & deductions
- Other Health Insurance
- All household members
- Is anyone a Former Foster Child.

EFFECTIVE FOR SERVICES: MONTHS YEAR YEAR  
 APPLICANT'S HOME PHONE: (AREA) (PHONE) (EXT)  
 APPLICANT'S WORK PHONE: (AREA) (PHONE) (EXT)  
 APPLICANT'S FAX: (AREA) (PHONE) (EXT)  
 MEDICAL IDENTIFICATION NUMBER: \_\_\_\_\_  
 QUALIFIED HOSPITAL PRELIMINARY ELIGIBILITY DETERMINATION: YES  NO   
 HEALTH INSURANCE: YES  NO   
 APPLICANT'S NAME: LAST FIRST MIDDLE INITIAL: \_\_\_\_\_  
 MAIDEN NAME: \_\_\_\_\_  
 BORN: MONTH DAY YEAR  
 APPLICANT'S ADDRESS: \_\_\_\_\_  
 TELEPHONE NUMBER: \_\_\_\_\_  
 APARTMENT/UNIT NUMBER: \_\_\_\_\_  
 SOCIAL SECURITY NUMBER: \_\_\_\_\_  
 (APPLICANT)  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTY OF RESIDENCE: \_\_\_\_\_  
 WHAT JOB DID YOU LEAVE FOSTER CARE? \_\_\_\_\_  
 IF WHAT STATE DID YOU LEAVE FOSTER CARE? \_\_\_\_\_

ID	TAX FILED HOUSEHOLD	MONTHLY GROSS TAXABLE INCOME	MONTHLY DEDUCTIONS	MONTHLY NET TAXABLE INCOME	RELATION TO APPLICANT	DATE OF BIRTH	SEX	AGE	MONTHLY DEDUCTIONS		
									TYPE	AMOUNT	PERCENT
01	YES <input type="checkbox"/> NO <input type="checkbox"/>				SELF						
02	CHILDREN CHILD: <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05				APPLICANT'S STEPPARENT NAME OF PREGNANT WOMAN: _____						
03											
04											
05											

**SWORN STATEMENT OF APPLICANT:**

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE BENEFIT FROM THE STATE MEDICAID PLAN SUBJECT TO COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (SUCH) WILL EXTEND TO MY CONTINUED ELIGIBILITY WHEN I SUBMIT A HEALTHCARE COVERAGE APPLICATION.

I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PERMITTED RESIDENT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MYSELF, MY FAMILY, PREGNANCY, RESIDENCY, TAX STATUS, MONTHLY DEDUCTIONS, AND DEDUCTIONS, FOSTER CARE 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 BIRTH OF SUCH OFFSPRING OCCURS OR THE END OF MY CONTINUED 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.DHS.GA.GOV](http://www.dhs.ga.gov) OR CALL 1-800-454-7800 (TDD) 1-800-454-7800 FAX 1-800-762-0311.

DATE OF APPLICATION: \_\_\_\_\_ APPLICANT'S SIGNATURE: \_\_\_\_\_

\*By providing false information, you will make us in administering our programs in a non-discriminatory manner. This does not require us give you this information and it will not affect your eligibility or benefit level.

DATA USE ONLY (01/2010)

TOTAL GROSS TAXABLE INCOME: \_\_\_\_\_ NET TOTAL NOT INCOME: \_\_\_\_\_  
 MEDICARE IN-HOUSEhold DEDUCTION: \_\_\_\_\_ 1% P.L. DEDUCTION: \_\_\_\_\_  
 POVERTY INCOME LEVEL: \_\_\_\_\_ TOTAL NET INCOME: \_\_\_\_\_  
 APPLICANT IS  ELIGIBLE OR  INELIGIBLE FOR PREGNANT/ELIGIBILITY MEDICAID  
 THE WOMAN FOR WHOM THIS PRELIMINARY DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY \_\_\_\_\_ WEEKS PREGNANT WITH \_\_\_\_\_ (FETUSES). HER EXPECTED DELIVERY DATE IS \_\_\_\_\_  N/A  
 I HAVE OBTAINED A HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE PASSED IT TO SUCH AT THE BIRTH: YES  (Include in FF Packet) NO  (Indicate Reason) \_\_\_\_\_  
 DATE OF COMPLETION: \_\_\_\_\_ COMPLETED BY (PLEASE PRINT): \_\_\_\_\_ TITLE: \_\_\_\_\_  
 (DIRECT PHONE NUMBER) \_\_\_\_\_ (QUALIFIED HOSPITAL PHONE) \_\_\_\_\_  
 (QUALIFIED HOSPITAL NAME AND ADDRESS) \_\_\_\_\_ (IF PROVIDED) \_\_\_\_\_  
 REIMBURSEMENT FOR MEDICAID SERVICES THROUGH THE PREGNANT/ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL SERVICES OR DELIVERY

# How to determine eligibility for §435.110 Parent/Caretaker with Child(ren)

Provides Medicaid coverage for Parent(s) or Caretaker(s) with at least one qualifying child.

The Eligibility Criteria is:

- ❖ Tax Filer or Non Tax Filer Status
- ❖ Exceptions per ACA
- ❖ Net Taxable Income must be at or below limit
- ❖ GA Resident
- ❖ Citizen or Qualified Immigrant

# Example of Parent/Caretaker with Child(ren)

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 \$2,310.00, per month. She pays \$184 monthly for vision insurance (pre-tax). Her husband is employed as a machinist and earns \$2,693.00, per month. He pays \$300 monthly for MARTA (pre-tax), \$298 monthly for dental insurance and \$800 monthly alimony to his ex- wife. Mr. Brown file taxes jointly with his wife and claims all the children as dependents. Michele receives \$1,022.00, per month, child- support for her daughter.

## Determine Budget Group:

Ms. Brown, Mr. Brown, her Daughter(15), and 3 mutual children (ages 8, 10, 11) and expected twins.

Budget group of 8



# Complete PE Medicaid Application Parent/Caretaker With Child(ren)

- Basic Demographics
- Tax filing status if so
- Dependents you claim
- Income & deductions
- Other Health Insurance
- All household members
- Is anyone a Former Foster Child.

EFFECTIVE FOR SERVICES: MONTH DAY YEAR  
 IF PROVIDED CONTACT CENTER: PHONE: 1.800.766.4664 FAX: 1.800.483.1094  
 MEDICARE IDENTIFICATION NUMBER:

(QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY DETERMINATION) HEALTH INSURANCE:  YES  NO  
 APPLICANT NAME: \_\_\_\_\_ MOTHER NAME: \_\_\_\_\_ FORMER FOSTER CARE:  YES  NO  
 APPLICANT ADDRESS: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_ WHAT AGE DID YOU LEAVE FOSTER CARE? \_\_\_\_\_  
 APARTMENT/LOT NUMBER: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ (PERSONAL) IN WHAT STATE DID YOU RECEIVE FOSTER CARE? \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTY OF RESIDENCE: \_\_\_\_\_

TAX PAYER HOUSEHOLD	NON-TAX PAYER HOUSEHOLD	DATE OF BIRTH	SEX	RELATION TO APPLICANT	MONTHLY GROSS TAXABLE INCOME			MONTHLY DEDUCTIONS		MONTHLY NET TAXABLE INCOME
					TYPE	AMOUNT	PERCENT	PERCENT	AMOUNT	
IN				SELF						
IN										
IN										
IN										

SWORN STATEMENT OF APPLICANT:  
 I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE BIRTH FROM THE STATE MEDICAID-BIRM PROJECT OR COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (SACS) WILL DETERMINE MY CONTINUING ELIGIBILITY WHEN I SUBMIT A HEALTHCARE COVERAGE APPLICATION.  
 I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LEGALLY PERMANENT RESIDENT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MYSELF, MY FAMILY, PREGNANCY, RESIDENCY, TAX STATUS, POST-TAX DEDUCTIONS, USA DEDUCTIONS, FOSTER CARE STATUS AND INCOME.  
 I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (DENTAL AND MEDICAL INSURANCE).  
 I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY FROM THE MONTH IN WHICH THE BIRTH OR SACS 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.MEDICAID.GA.GOV](http://WWW.MEDICAID.GA.GOV) OR CALL 1.877.464.6287 (TDD) 1.800.766.4664.  
 DATE OF APPLICATION: \_\_\_\_\_ APPLICANT'S SIGNATURE: \_\_\_\_\_  
\*By providing this information, you will assist in administering our program in a cost-effective manner. You are not required to give us this information and it will not affect your eligibility or health care.  
(Area and address)

TOTAL GROSS TAXABLE INCOME - \_\_\_\_\_ NET MONTHLY INCOME - \_\_\_\_\_  
 NUMBER OF DEPENDENT CHILDREN - \_\_\_\_\_ FEDERAL DEDUCTIONS - \_\_\_\_\_  
 MONTHLY INCOME LEVEL - \_\_\_\_\_ TOTAL NET INCOME - \_\_\_\_\_  
 APPLICANT IS  ELIGIBLE OR  INELIGIBLE FOR PRESUMPTIVE ELIGIBILITY (MEDICAID)  
 THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY \_\_\_\_\_ WEEKS PREGNANT WITH \_\_\_\_\_ (FETUS/US) AND EXPECTED DELIVERY DATE IS \_\_\_\_\_  N/A  
 I HAVE OBTAINED A HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE PAID \$ TOUCH AT THAT TIME:  YES (Included in PE Fee)  NO (Non-Resident)

DATE OF COMPLETION: \_\_\_\_\_ COMPLETED BY (PLEASE PRINT): \_\_\_\_\_ TITLE: \_\_\_\_\_  
 (QUALIFIED HOSPITAL NUMBER) IDENTIFICATION OF QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_  
 QUALIFIED HOSPITAL NAME AND ADDRESS: \_\_\_\_\_ OFF PROVIDER ID: \_\_\_\_\_

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

# How to calculate income for §435.110 Parent/Caretaker with Child(ren)

## Determine Income to be counted:

\$2310.00 Mrs. Brown's earned income

\$ -184.00 Vision Insurance/Pre-tax

\$ 2126.00 Mrs. Brown's net taxable income

\$ 2126.00 Mrs. Brown's net taxable income

\$ 1295.00 Mr. Brown's net taxable income

\$ 3421.00

\$ -168.00 5% FPL

\$ 3253.00 = total net taxable income for the BG of 8

\$ 2693.00 Mr. Brown's earned income

\$ -300.00 MARTA/Pre-tax

\$ 2393.00

\$ - 298.00 Dental Insurance/Pre-tax

\$ -800.00 Alimony/1040 Deduction

\$1295.00 Mr. Brown's net taxable inc

# How to determine eligibility for §435.110 Parent/Caretaker with Child(ren)

**Pregnancy Medicaid BG of 8 income Limit = \$7,497**

**Parent/Caretaker with Child(ren) BG of 8 income Limit = \$970**

**Children Under 19 Years of Age BG of 8 income limit = \$4,532**

**Presumptive Eligibility for Children Under 19 years of Age Medicaid and Pregnant Women Medicaid.**

(Michelle and children are eligible for Presumptive Medicaid.)

## §435.1102 Children Under 19 Years of Age

Provides Medicaid coverage for a child(ren) under 19 years of age.

- ❖ Tax Filer or Non Tax Filer Status
- ❖ Exceptions per ACA
- ❖ Net Taxable Income must be at or below limit
- ❖ GA Resident
- ❖ Citizen or Qualified Immigrant

## Example

# §435.1102 Children Under 19 Years of Age

Marcy Jones lives with her husband, her daughter age 15, two mutual children ages 5 & 7 years old, and his son. Marcy is employed and earns \$1,100.00, per month. Her husband is employed as a machinist and earns \$2,228.00, per month. Marcy receives \$675.00, per month, child- support for her daughter. Mr. Jones is expected to file a tax return and claim his wife, his step daughter, his son age 17, and the two mutual children. **Marcy is applying for Medicaid for the two mutual children only.** Who is included in the budget group?

**Mr. and Mrs. Jones, their two children and Ms. Jones' daughter and Mr. Jones' son will all be included in the budget group.**

**Budget group of 6.**



# Complete PE Medicaid Application Children Under 19 Years of Age

- Basic Demographics
- Tax filing status if so
- Dependents you claim
- Income & deductions
- Other Health Insurance
- All household members
- Is anyone a Former Foster Child.

**APPLICANT FOR SERVICES**  
 MEDICAID IDENTIFICATION NUMBER: [REDACTED]

**IF PROVIDER CONTACT CENTER**  
 NO. NOT USED  
 TUCKER, GA 30084

**PHONE 1 (800) 764-6644**  
 FAX 1 (800) 764-6644

**QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY DETERMINATION**

HEALTH INSURANCE:  YES  NO

APPLICANT'S NAME: [REDACTED] MAIDEN NAME: [REDACTED] **FORMER FOSTER CHILD:**

APPLICANT'S ADDRESS: [REDACTED] TELEPHONE NUMBER: [REDACTED] **FORMER FOSTER CARE:**  YES  NO

APPLICANT'S SOCIAL SECURITY NUMBER: [REDACTED] SOCIAL SECURITY NUMBER: [REDACTED] **WHAT AGE DO YOU LEAVE FOSTER CARE?**

CITY: [REDACTED] STATE: [REDACTED] ZIP CODE: [REDACTED] COUNTY OF RESIDENCE: [REDACTED] **IN WHAT STATE DID YOU RECEIVE FOSTER CARE?**

LAST FILED RETURNED FROM TAX FILED HOUSEHOLD	YES	NO	DATE OF BIRTH	SEX	RELATION TO APPLICANT	MONTHLY GROSS TAXABLE INCOME			MONTHLY DEDUCTIONS		MONTHLY NET TAXABLE INCOME
						AMOUNT	TYPE	AMOUNT	TYPE		
1					SELF						
2											
3											
4											

**SWORN STATEMENT OF APPLICANT:**  
 I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE BIRTH FROM THE FIRST MEDICAID (BAND) PROJECT OR COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (CDFS) WILL DETERMINE MY CONTINUING ELIGIBILITY WHEN I SUBMIT A HEALTHCARE COVERAGE APPLICATION.

I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR A LEGALLY PERMITTED RESIDENT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MYSELF, MY FAMILY, MY RESIDENCY, MY INCOME, MY STATE, MY MONTHLY DEDUCTIONS, MY DEDUCTIONS, FOSTER CARE STATUS AND OCCURRENCE.

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 BIRTH OR CDFS 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 THE ONLINE SYSTEM OR CALL 1-800-764-6644 (TDD) 1-800-764-6644 (V). FAX 1-800-764-6644.

DATE OF APPLICATION: [REDACTED] APPLICANT'S SIGNATURE: [REDACTED]

If you falsify these statements, you will commit an administrative law violation in a non-discriminatory manner. This is not required to give written information and will not affect your eligibility or benefit level.

(This area is optional)

TOTAL GROSS TAXABLE INCOME - [REDACTED] MONTHLY NET INCOME - [REDACTED]  
 MINIMUM IN-BUDGET AMOUNT - [REDACTED] HEALTH DEDUCTION - [REDACTED]  
 FOSTER CARE LEVEL - [REDACTED] TOTAL NET INCOME - [REDACTED]

APPLICANT IS  ELIGIBLE OR  UNELIGIBLE FOR PRESUMPTIVE ELIGIBILITY MEDICAID.

THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY [REDACTED] WEEKS PREGNANT WITH [REDACTED] FETUS(ES). HER EXPECTED DELIVERY DATE IS [REDACTED]  NO.

I HAVE OBTAINED A HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FAXED IT TO CDS AT THE ADDRESS:  YES (included in PE Packet)  NO (separately)

DATE OF COMPLETION: [REDACTED] COMPLETED BY (PLEASE PRINT): [REDACTED] TITLE: [REDACTED]

QUALIFIED HOSPITAL NUMBER: [REDACTED] SIGNATURE OF QUALIFIED HOSPITAL PROVIDER: [REDACTED]

QUALIFIED HOSPITAL NAME AND ADDRESS: [REDACTED] (IF PROVIDER IS [REDACTED])

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

# Calculate Income Budget

## §435.1102 Children Under 19 Years of Age

### Marcy Jones Income

\$1,100.00 per month

(her net income)

- Mrs. Jones receives \$675. excluded. (Regardless of how they receive child support, and amount, none of the child support is counted as it is considered non-taxable income per IRS regulations)

### Mr Jones Income

\$2,228.00 per month

(his net income)

\$2,228.00 Mr. Jones net mo inc

\$1,100.00 Mrs. Jones

\$3,328.00 total monthly net  
income

PE Children Under 19 Years child Age 5 BG 6 income limit = \$3528.00

PE Children Under 19 years child Age 7 BG 6 income limit = \$3610.00

Both children are PE eligible



# §435.1103 Pregnant Women

Provides Medicaid coverage for a pregnant woman.

- ❖ Tax Filer or Non Tax Filer Status
- ❖ Exceptions per ACA
- ❖ Net Taxable Income must be at or below limit
- ❖ GA Resident
- ❖ Citizen or Qualified Immigrant
- ❖ Pregnancy is not medically verified
- ❖ Can only be PE approved once per pregnancy



# Example

## §435.1103 Pregnant Women

Jane Lyons is pregnant and lives with her 3 year old son. She earns \$ 1500 a month. She is applying for everyone in the household. Jane does not expect to file a tax return. Who is included in the budget group?

Answer: Jane, unborn child, and her 3yr old son. Budget Group of 3

Now if Jane's live-in boyfriend Jimmy Stewart was the father of her son, the budget group would include Jane, her fetus , her 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 not to file a joint tax return, they would all be counted in the budget group and include the unborn child because they all live together.

# Complete PE for PGW Medicaid Application

- Basic Demographics
- Who is Pregnant
- Tax filing status if so:
- Dependents you claim
- Income & deductions
- Other Health Insurance
- All household members
- Is anyone a Former Foster Child.

EFFECTIVE FOR SERVICES BEGINNING \_\_\_\_\_ MONTH DAY YEAR

IF PROVIDER CONTACT CENTER P.O. BOX 10200 TUCKER, GA 30085-0200

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

MEDICAID IDENTIFICATION NUMBER \_\_\_\_\_

VALID FOR LISTED MONTH ONLY

**PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANCY MEDICAID**

APPLICANT'S NAME: \_\_\_\_\_ MAIDEN NAME: \_\_\_\_\_

APPLICANT'S ADDRESS: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

APARTMENT/LOT NUMBER: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ (optional)

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTY OF RESIDENCE: \_\_\_\_\_

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

ID	TAX FILER HOUSEHOLD	NON TAX FILER HOUSEHOLD	DATE OF BIRTH	SEX	RELATION TO APPLICANT	MONTHLY GROSS TAXABLE INCOME		MONTHLY DEDUCTIONS		MONTHLY NET TAXABLE INCOME
						TYPE	AMOUNT	PRE-TAX DEDUCTION	IMD DEDUCTION	
01	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			SELF					
02	UNBORN CHILD <input type="checkbox"/> NA <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 (SMA) 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.DHS.GA.GOV](http://WWW.DHS.GA.GOV) OR CALL 1-877-424-4766 (TDD/TTY 1-866-254-1125) FAX 1-888-760-4055.

DATE OF APPLICATION: \_\_\_\_\_ APPLICANT'S SIGNATURE: \_\_\_\_\_

TOTAL GROSS TAXABLE INCOME = \_\_\_\_\_ SUBTOTAL NET INCOME = \_\_\_\_\_  
 NUMBER IN BUDGET GROUP = \_\_\_\_\_ 5% PPL DEDUCTION = \_\_\_\_\_  
 POVERTY INCOME LEVEL = \_\_\_\_\_ TOTAL NET INCOME = \_\_\_\_\_

APPLICANT IS  ELIGIBLE OR  INELIGIBLE FOR PRESUMPTIVE ELIGIBILITY MEDICAID

THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY \_\_\_\_\_ WEEKS PREGNANT WITH \_\_\_\_\_ (PT/US/IS) HER EXPECTED DELIVERY DATE IS \_\_\_\_\_

I HAVE OBTAINED A SEPARATE 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: \_\_\_\_\_

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

\*By providing false information, you will interfere in administering our program in a non-discriminatory manner. You are not required to give us this information and it will not affect your eligibility or benefit level. DMS 01/04/07/04

# Calculate income for Pregnant Women

Jane Lyons is pregnant and lives with her 3 year old son. She earns \$ 1500 a month. She is applying for everyone in the household. Jane does not expect to file a tax return.

Her net taxable income is \$1,500.00

PE for pregnant woman BG of 3 income limit = \$3,684

PE for Children under 19 (3yrs old) BG of 3 income limit = \$2,495.00

# GAMMIS ON-LINE PROCEDURES

- Online Procedures for Approvals
- Manual Procedures for Approvals
- Denials

# ON-LINE PROCEDURES FOR APPROVALS

- The online process allows certain information contained on the completed PE application (Form DMA 632H) to be entered into GAMMIS system.
- Data entry allows immediate update of DCH/GAMMIS file & immediate generation of a Medicaid identification number.
- The interview with applicant and appropriate forms **MUST** be completed.
- If ID is already known to the system use the **same** ID.



# On-line Procedures for Approvals

If all data are enter correctly a temporary Medicaid certificate is produced. **DMA 634H**

1. Print out two copies, one to applicant. This serves as notice.
2. Retain one copy for the record, with the application **632H**.
3. **ASAP** Fax PE packet to Gloria Hill

(404) 463 - 2538

(PE packet consists of the DMA 632H; a copy of the citizenship affidavit, form 216, and HIPPA form 5460 )



# Manual Approvals

Approved PE applications only, call HP to have manually updated. 1-800-766-4456

1. Give applicant DMA 643H, Approval Notice and
2. Retain one copy for the record, with the application **632H.**
3. **ASAP** Fax PE packet to Gloria Hill  
(404) 463 - 2538

(PE packet consists of the DMA 632H; a copy of the citizenship affidavit, form 216, and HIPPA form 5460 )

# Procedural Responsibilities of Qualified Hospitals Denials

For any applicant determined NOT eligible for presumptive coverage shall:

- ✓ inform the applicant verbally and in writing via form 634H (**Denial**)
- ✓ Advise the applicant that if their circumstances change, they may have another determination of PE performed by QH.
- ✓ Inform applicant the application for healthcare coverage has been forward to the local RSM/DFCS office for a formal determination of eligibility.
- ✓ Fax a copy of the completed PE Medicaid application form 632H, the signed healthcare coverage application (if completed) form 216 Declaration of Citizenship/Immigration status, the HIPPA form, and a copy of the 634H Denial form to DCH within 5 calendar days.
- ✓ Provide the applicant with the address and telephone number of their RSM/DFCS office.
- ✓ Inform the applicant about Planning for Health Babies (P4HB)

# Reasons for Denials

1. The applicant is not a U.S. citizen or qualified immigrant.
2. The applicant's net family taxable income is above the allowable percentage of the federal poverty level limit.
3. The applicant is not a Georgia Resident.
4. The applicant is not the appropriate age for the PE Medicaid.
5. The applicant is not a Former/FosterCare Child.
6. The applicant states she is not pregnant.
7. Unable to determine, applicant refuses to verbally give tax status information

# PE Denial Process

When the PE Medicaid 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.

1. Complete and give the applicant a copy of the **DMA 634H Denial, Notice of Action**. In the case of a denial, this is the **only** form the applicant receives.
2. Within five (5) calendar days the PE Medicaid application is completed, fax the PE packet to DCH (404) 463 - 2538, or scan the complete PE packet to [pecorrections@dch.ga.gov](mailto:pecorrections@dch.ga.gov).



# PE Denial Process

If a healthcare 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](http://www.healthcare.gov), or you may call the FFM any time at 1-800-318-2596, TTY 1-855-889-4325.



# GAMMIS

List of PE Specialty Codes

GAMMIS Screen Shots



# GAMMIS SPECIALTY CODES CHART

**Presumptive Women’s Health Medicaid 800**

Presumptive WHM for women with breast and/or cervical cancer determined by Qualified providers only.

**Presumptive Parent/Caretaker Adult Medicaid 801**

Presumptive Parent/Caretaker Medicaid benefits for eligible adults that have a qualifying child.

**Presumptive Parent/Caretaker Child Medicaid 802**

Presumptive Parent/Caretaker Medicaid benefits for eligible children up to age 19 and the adult(s) who are responsible for those children.

**Presumptive Child(ren) under 19 Years of Age 806**

Presumptive Medicaid to eligible children through the month 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).

**Presumptive Former Foster Care 852**

Continuation of Foster Care Medicaid for former foster care members that have aged out of Foster Care Medicaid or CHAFEE Medicaid and are not longer eligible for Foster Care Medicaid and are under 26 years of age.

**Presumptive Pregnant Woman 865**

Presumptive Pregnant Medicaid for pregnant woman determined by Qualified providers only.

# GAMMIS HPE Activation

The screenshot displays the GAMMIS HPE Activation interface. At the top, there are logos for the Georgia Department of Community Health, GAMMIS (Georgia Medicaid Management Information System), and HP. A navigation menu includes links for Home, Contact Information, Member Information, Provider Information, Provider Enrollment, Nurse Aide/Medication Aide, EDI, Pharmacy, Account, Providers, Training, Claims, Eligibility, Presumptive Activations, Health Check, Prior Authorization, Reports, Trade Files, Home, Secure Home, Demographic Maintenance, Newborn Activations, Provider Rates, Bed Registry, Procedure Search, and EOB Search. A callout box points to the 'Hospital Activations' link in the menu. Below the menu, there is an alert message: '(click to hide) Alert Message posted 2/24/15. This site is for testing purposes only. Any information provided on it is for demonstration purposes only.' The main content area shows 'User Information - Provider 000155933X' and 'Provider Service Location Information' for Humility of Mary-St. Elizabeth's Hospital. The provider information includes: Name: HUMILITY OF MARY-ST. ELIZABETH'S, Address 1: 1044 BELMONT AVE, Address 2: (blank), City, State: YOUNGSTOWN, OH, Zip: 44504-1006, Medicaid Provider ID: 000155933X, National Provider ID: 1548296106, and Provider Type: HOSPITAL. A 'Messages' section at the bottom indicates '\*\*\* No rows found \*\*\*'.

**Navigation Callout:** Navigate to Hospital Activations Tab

**Alert Message:** (click to hide) Alert Message posted 2/24/15. This site is for testing purposes only. Any information provided on it is for demonstration purposes only.

User Information - Provider 000155933X	
<b>Provider Service Location Information</b>	
Name	HUMILITY OF MARY-ST. ELIZABETH'S
Address 1	1044 BELMONT AVE
Address 2	
City, State	YOUNGSTOWN, OH
Zip	44504-1006
Medicaid Provider ID	000155933X
National Provider ID	1548296106
Provider Type	HOSPITAL

**Messages**  
\*\*\* No rows found \*\*\*

# GAMMIS Screen for GA Medicaid ID

**Note:** By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate from the next page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

[submit](#) [cancel](#)

**Presumptive Eligibility for Hospital Request** ? ⌵

Household Information

Qualifying Member ID  Number of Adults\*   
Net/Taxable Income\*  Number of Children\*

Member Information

Member ID  Gender\*    
First Name\*  Birth Date\*    
Last Name\*  SSN    
MI  Home Phone   
Suffix   Other Phone   
Race\*   Ethnicity\*    
Citizenship\*

Mailing Address

Address\*   
Address 2   
City\*   
Zip\*  00000

Residential Address

Same as Mailing Address

Address\*   
Address 2   
City\*   
Zip\*  00000  0000

State\*  GA   
County\*

Eligibility Information

Medicaid Application Submitted?\*    
Application Date\*    
Is Member Pregnant?    
Pregnancy Due Date    
Number of Expected Births   
Determination/Eligibility Begin Date 03/17/2015  
Denial Reason    
Aid Category

Message from webpage

 Does this member have a Georgia Medicaid ID number? If Yes, please enter their Georgia Medicaid ID to prepopulate the member's information. If not, please continue entering the new member's information.

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[top of page](#)

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# GAMMIS- Enter Income and Category

Enter the members' net/taxable income from form 632H

**Presumptive Eligibility for Hospital Request**

Household Information  
Qualifying Member ID   
Net/Taxable Income\*

Member Information  
Member ID   
First Name\*   
Last Name\*   
MI   
Suffix   
Race\*   
Citizenship\*

Mailing Address  
Address\*   
Address 2   
City\*   
Zip\*

Residential Address  
Same as Mailing Address   
Address   
Address 2   
City   
Zip

Eligibility Information  
Medicaid Application Submitted?\*   
Is Member Pregnant?   
Number of Expected Births   
Denial Reason   
Aid Category

Number of Adults\*   
Number of Children\*   
Gender\*   
Birth Date\*   
SSN   
Home Phone   
Other Phone   
Ethnicity\*   
Primary Household Language\*   
State\*   
County\*   
State   
County   
Application Date\*   
Pregnancy Due Date   
Determination/Eligibility Begin Date

Select the members' aid category from the drop down box

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# GAMMIS- Submit and the Begin Date

**Note:** By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate from the next page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

Click the 'submit' button after all of the information has been entered on the screen

[submit](#) [cancel](#)

**Presumptive Eligibility for Hospital Request**

Household Information

Qualifying Member ID

Net/Taxable Income\* \$505.00

Member Information

Member ID

First Name\* SHEILA

Last Name\* BAKER

MI

Suffix

Race\* Caucasian

Citizenship\* US CITIZEN

Mailing Address

Address\* 376 GREEN OAK DRIVE

Address 2

City\* ATLANTA

Zip\* 30331 0000

Residential Address

Same as Mailing Address

Address

Address 2

City

Zip

Eligibility Information

Medicaid Application Submitted?\* YES

Is Member Pregnant? NO

Number of Expected Births

Denial Reason

Aid Category PE Adult (Parent/Caretaker with child(ren))

Number of Adults\* 1

Number of Children\* 2

Gender\* Female

Birth Date\* 08/01/1980

SSN 898-54-9632

Home Phone

Other Phone

Ethnicity\* Not Applicable

Primary Household Language\* ENGLISH

State\* GA

County\*

State

County

Application Date\* 03/17/2015

Pregnancy Due Date

Determination/Eligibility Begin Date 03/17/2015

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[top of page](#)

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**Determination/Eligibility Begin Date** is the current date and cannot be modified. Coverage begins on the date the qualified hospital makes the determination.



# Medicaid ID Generated & Certificate Displayed

After the submit button is selected the request is processed and the members new Medicaid ID is generated and the certificate will display.

Note: By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate from the next page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

The following messages were generated:  
The presumptive eligibility request was successfully processed. The Medicaid ID is 222113132841. Select the following link to open a [certificate of eligibility](#). If a window does not appear or if you close the initial certificate.

**Presumptive Eligibility for Hospital Request**

Household Information	
Qualifying Member ID	Number of Adults 1
Net Taxable Income \$505.00	Number of Children 2

Member Information	
Member ID	Gender Female
First Name SHEILA	Birth Date 08/01/1980
Last Name BAKER	SSN 898-54-9632
MI	Home Phone
Suffix	Other Phone
Race Caucasian	Ethnicity Not Applicable
Citizenship US CITIZEN	Primary Household Language ENGLISH

Mailing Address	
Address 376 GREEN OAK DRIVE	State GA
Address 2	County 060-Fulton
City ATLANTA	
Zip 30331 0000	

Residential Address	
Same as Mailing Address <input checked="" type="checkbox"/>	State
Address	County
Address 2	
City	
Zip	

Eligibility Information	
Medicaid Application Submitted? YES	Application Date 03/17/2015
Is Member Pregnant? NO	Pregnancy Due Date
Number of Expected Births	Determination/Eligibility Begin Date 03/17/2015
Denial Reason	
Aid Category PE Adult (Parent/Caretaker with child(ren))	



# GAMMIS CASE DATA

The screenshot displays the GAMMIS web application interface. At the top, there are logos for the Georgia Department of Community Health, GAMMIS, and HP. The page title is "Welcome, Humility Of Mary--St Elizabeths" and the date is "Tuesday, March 17, 2015". A navigation menu includes links for Home, Contact Information, Member Information, Provider Information, Provider Enrollment, Nurse Aide/Medication Aide, EDI, Pharmacy, Account, Providers, Training, Claims, Eligibility, Presumptive Activations, Health Check, Prior Authorization, Reports, and Trade Files. The current page is "User Information - Provider 000155933X".

A message box titled "Message from webpage" is overlaid on the form, containing the text: "Qualifying Member information has been populated based on the ID provided. Any values changed below will be updated in the system if submitted." The message box has a yellow warning icon and "OK" and "cancel" buttons.

The main form is titled "Presumptive Eligibility for Hospital Request". It contains several sections of data entry fields:

- Household Information:** Qualifying Member ID (222113132641), Net/Taxable Income\* (\$505.00).
- Member Information:** Member ID, First Name\*, Last Name\*, MI, Suffix, Race\*, Citizenship\*.
- Mailing Address:** Address\* (376 GREEN OAK DRIVE), Address 2, City\* (ATLANTA), Zip\* (30331 0000).
- Residential Address:** Same as Mailing Address (checkbox), Address\* (376 GREEN OAK DRIVE), Address 2, City\* (ATLANTA), Zip\* (30331 0000).
- Other Information:** Number of Children\* (2), Gender\*, Birth Date\*, SSN (000-00-0000), Home Phone, Other Phone, Ethnicity\*, Primary Household Language\* (ENGLISH), State\* (GA), County\* (060-Fulton).

A red arrow points to the "Qualifying Member ID" field. A blue callout box on the left contains the text: "The system will prepopulate the fields with the case data." with arrows pointing to the "Qualifying Member ID" and "Net/Taxable Income\*" fields.



# GAMMIS – Select Category for Member

Qualifying Member ID: 222113132841  
Net/Taxable Income\*: \$505.00

**Member Information**  
Member ID:   
First Name\*: SHAWN  
Last Name\*: BAKER  
MI:   
Suffix:   
Race\*: Caucasian  
Citizenship\*:

**Mailing Address**  
Address\*: 376 GREEN OAK DRIVE  
Address 2:   
City\*: ATLANTA  
Zip\*: 30331 0000

**Residential Address**  
Same as Mailing Address:   
Address\*: 376 GREEN OAK DRIVE  
Address 2:   
City\*: ATLANTA  
Zip\*: 30331 0000

**Eligibility Information**  
Medicaid Application Submitted?: YES  
Is Member Pregnant?:   
Number of Expected Births:   
Denial Reason:   
Medicaid Category:

Number of Adults\*: 1  
Number of Children\*: 2

Gender\*: Male  
Birth Date\*: 04/05/2000  
SSN: 875-25-9863  
Home Phone:   
Other Phone:   
Ethnicity\*: Not Applicable  
Primary Household Language\*: ENGLISH

State\*: GA  
County\*: 060-Fulton

State\*: GA  
County\*: 060-Fulton

Application Date\*: 03/17/2015  
Pregnancy Due Date:   
Determination/Eligibility Begin Date: 03/17/2015

Select the appropriate Medicaid category for the member.

PE Adult (Parent/Caretaker with child(ren))  
PE Child of (Parent/Caretakers with child(ren))  
PE Children Under 19 Years of Age  
PE Former Foster Care Child (LA=FF)

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# GAMMIS Submit Request for the Member

Note: By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

Select submit to process the request for the member

Rectangular Snip

PE Adult (Parent/Caretaker with child(ren))  
 PE Child of Parent/Caretakers with child(ren)  
 PE Children Under 19 Years of Age  
 PE Former Foster Care Child (LA=FF)



# Other Qualifying Members are Added

The other qualifying member is successfully added and the certificate of eligibility is generated.

Note: By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate from the next page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

The following messages were generated:  
The presumptive eligibility request was successfully processed. The Medicaid ID is 222113132851. Select the following link to open a [certificate of eligibility](#), if a window does not appear or if you close the initial certificate.

Presumptive Eligibility for Hospital Request	
<b>Household Information</b>	
Qualifying Member ID	222113132841
Net/Taxable Income	\$505.00
<b>Member Information</b>	
Member ID	
First Name	JENNIFER
Last Name	BAKER
MI	
Suffix	
Race	Caucasian
Citizenship	US CITIZEN
<b>Mailing Address</b>	
Address	376 GREEN OAK DRIVE
Address 2	
City	ATLANTA
Zip	30331 0000
<b>Residential Address</b>	
Same as Mailing Address	<input type="checkbox"/>
Address	376 GREEN OAK DRIVE
Address 2	
City	ATLANTA
Zip	30331 0000
<b>Eligibility Information</b>	
Medicaid Application Submitted?	YES
Is Member Pregnant?	NO
Number of Expected Births	
Denial Reason	
Aid Category	PE Child of (Parent/Caretakers with child/ren)
Number of Adults	1
Number of Children	2
Gender	Female
Birth Date	02/27/2009
SSN	858-22-2121
Home Phone	
Other Phone	
Ethnicity	Not Applicable
Primary Household Language	ENGLISH
State	GA
County	060-Fulton
State	GA
County	060-Fulton
Application Date	03/17/2015
Pregnancy Due Date	
Determination/Eligibility Begin Date	03/17/2015



# GAMMIS – Qualifying Members Must be Entered First

**Member Information**

Member ID: [ ]  
First Name\*: SALLY  
Last Name\*: JONES  
MI: [ ]  
Suffix: [ ]  
Race\*: Black  
Citizenship\*: US CITIZEN

**Mailing Address**

Address\*: 456 FLAT SHOALS AVE  
Address 2: APT 1212  
City: DECATUR  
Zip\*: 30034 0000

**Residential Address**

Same as Mailing Address:   
Address: [ ]  
Address 2: [ ]  
City: [ ]  
Zip: [ ]

**Eligibility Information**

Medicaid Application Submitted?: YES  
Is Member Pregnant?: NO  
Number of Expected Births: [ ]  
Denial Reason: PE Adult (Parent/Caretaker with child(ren))  
Aid Category: PE Children Under 19 Years of Age

Gender\*: Female  
Birth Date\*: 07/06/2007  
SSN: 876-25-9874  
Home Phone: [ ]  
Other Phone: [ ]  
Ethnicity\*: Not Applicable  
Primary Household Language\*: ENGLISH  
State\*: GA  
County\*: 044-DeKalb  
Application Date\*: 03/17/2015  
Pregnancy Due Date: [ ]  
Determination/Eligibility Begin Date: 03/17/2015

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**REPORT FRAUD**

For households with a qualifying member and a denied member, the qualifying member must be entered first. The system will not allow you to generate the denial certificate without the qualifying member.



# ADD MEMBER & CREATE NEW MEDICAID ID & CREATE DENIAL CERTIFICATE

Note: By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate from the next page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

**The following messages were generated:**

The presumptive eligibility request was successfully processed. The Medicaid ID is 222113132852. Select the following link to open a [certificate of eligibility](#), if a window does not appear or if you close the initial certificate.

**Presumptive Eligibility for Hospital Request** ?

<b>Household Information</b>	
Qualifying Member ID	Number of Adults 1
Net/Taxable Income \$1,705.01	Number of Children 1
<b>Member Information</b>	
Member ID	Gender Female
First Name SALLY	Birth Date 07/06/2007
Last Name JONES	SSN 876-25-9874
MI	Home Phone
Suffix	Other Phone
Race Black	Ethnicity Not Applicable
Citizenship US CITIZEN	Primary Household Language ENGLISH
<b>Mailing Address</b>	
Address 456 FLAT SHDALS AVE	State GA
Address 2 APT. 1212	County 044-DeKalb
City DECATUR	
Zip 30034 0000	
<b>Residential Address</b>	
Same as Mailing Address <input checked="" type="checkbox"/>	State
Address	County
Address 2	
City	
Zip	
<b>Eligibility Information</b>	
Medicaid Application Submitted? YES	Application Date 03/17/2015
Is Member Pregnant? NO	Pregnancy Due Date
Number of Expected Births	Determination/Eligibility Begin Date 03/17/2015
Denial Reason	
Aid Category PE Children Under 19 Years of Age	

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**REPORT**



# CREATING THE DENIAL CERTIFICATE

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy  
Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files  
Home | Newborn Activations | Hospital Activations | Pregnant Women Activations | Women's Health Activations

**User Information - Provider 000155933X**

Note: By pressing the submit button, the next page that appears is the member information page. You can only print the temporary Medicaid Certificate one time. Please use the print button. Once you close the temporary Medicaid Certificate page, the certificate will be deleted.

**Presumptive Eligibility for Hospital Request**

Household Information  
Qualifying Member ID: 222113132852  
Net/Taxable Income\*: \$1,705.01

Member Information  
Member ID:   
First Name\*:   
Last Name\*:   
MI:   
Suffix:   
Race\*:   
Citizenship\*:

Mailing Address  
Address\*: 456 FLAT SHOALS AVE  
Address 2: APT 1212  
City\*: DECATUR  
Zip\*: 30034 0000

Residential Address  
Same as Mailing Address:   
Address\*: 456 FLAT SHOALS AVE  
Address 2: APT 1212  
City\*: DECATUR  
Zip\*: 30034 0000

Number of Adults:   
Number of Children\*: 1  
Gender\*:   
Birth Date\*:   
SSN: 000-00-0000  
Home Phone:   
Other Phone:   
Ethnicity\*:   
Primary Household Language\*: ENGLISH  
State\*: GA  
County\*: 044-DeKalb

Message from webpage  
Qualifying Member information has been populated based on the ID provided. Any values changed below will be updated in the system if submitted.  
OK

Creating the denial certificate: |Enter the qualifying member's ID, to pre-populate the case data.



# SELECT DENIAL REASON

Qualifying Member ID 222113132852  
Net/Taxable Income\* \$1,705.01

**Member Information**  
Member ID  
First Name\* AMBER  
Last Name\* JONES  
MI  
Suffix  
Race\* Black  
Citizenship\* US CITIZEN

**Mailing Address**  
Address\* 456 FLAT SHOALS AVE  
Address 2 APT 1212  
City\* DECATUR  
Zip\* 30034 0000

**Residential Address**  
Same as Mailing Address  
Address\* 456 FLAT SHOALS AVE  
Address 2 APT 1212  
City\* DECATUR  
Zip\* 30034 0000

**Eligibility Information**  
Medicaid Application Submitted? YES  
Is Member Pregnant? NO  
Number of Expected Births

Denial Reason Aid Category

Number of Adults\* 1  
Number of Children\* 1  
Gender\* Female  
Birth Date\* 08/15/1989  
SSN 000-00-0000  
Home Phone  
Other Phone  
Ethnicity\* Not Applicable  
Primary Household Language\* ENGLISH  
State\* GA  
County\* 044-DeKalb  
State\* GA  
County\* 044-DeKalb  
Application Date\* 03/17/2015  
Pregnancy Due Date  
Determination/Eligibility Begin Date 03/17/2015

NET TAXABLE INCOME EXCEEDS THE INCOME STANDARD  
NOT A FORMER FOSTER CARE CHILD  
NOT A GEORGIA RESIDENT  
NOT A QUALIFIED IMMIGRANT  
NOT PREGNANT  
NOT THE CORRECT AGE FOR THE MEDICAID  
UNABLE TO DETERMINE, APPLICANT REFUSES TO VERBALLY GIVE TAX STATUS INFORMATION

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Select the correct HPE denial reason from the drop down box.



# DENIAL CERTIFICATE GENERATED

The denial certificate is generated in a separate window. Print and give to member.

Note: By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate from the next page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

The following messages were generated:  
The presumptive eligibility request was successfully processed. Select the following link to open a [certificate of denial](#). If a window does not appear or if you close the initial certificate.

### Presumptive Eligibility for Hospital Request

<b>Household Information</b>	
Qualifying Member ID	222113132852
Net Taxable Income	\$1,705.01
<b>Member Information</b>	
Member ID	
First Name	AMBER
Last Name	JONES
MI	
Suffix	
Race	Black
Citizenship	US CITIZEN
<b>Mailing Address</b>	
Address	456 FLAT SHOALS AVE
Address 2	APT 1212
City	DECATUR
Zip	30034 0000
<b>Residential Address</b>	
Same as Mailing Address	<input type="checkbox"/>
Address	456 FLAT SHOALS AVE
Address 2	APT 1212
City	DECATUR
Zip	30034 0000
<b>Eligibility Information</b>	
Medicaid Application Submitted?	YES
Is Member Pregnant?	NO
Number of Expected Births	
Denial Reason	NET TAXABLE INCOME EXCEEDS THE INCOME STANDARD
Aid Category	
Number of Adults	1
Number of Children	1
Gender	Female
Birth Date	03/15/1989
SSN	000-00-0000
Home Phone	
Other Phone	
Ethnicity	Not Applicable
Primary Household Language	ENGLISH
State	GA
County	044-DeKalb
Application Date	03/17/2015
Pregnancy Due Date	
Determination/Eligibility Begin Date	03/17/2015

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A Medicaid ID is NOT generated



# PRESUMPTIVE ELIGIBILITY

QUALIFIED HOSPITALS

PERFORMANCE

STANDARDS



# Qualified Hospital PE Performance Standards

- DCH Medicaid Policy will review all QH PE determinations the first 6 months.
- DCH Medicaid Policy will look at the share of PE applicants who file a full Medicaid application and found eligible at the end of the first 6 months.
- After the first 6 months DCH Medicaid Policy requires 90% of PE applications be done correctly.
- Hospitals are to ensure that 100% of applicants are checked for existing Medicaid enrollment.



# Qualified Hospital PE Performance Standards

- Hospitals would be required to ensure that 95% to 100% of potential applicants are checked for recent PE determinations.
- QH PE standards will be established at the end of the first 6 months and based on data gathered during the initial 6 month implementation.
- Qualified Hospitals may be disqualified from conducting PE determinations for failure to adhere to the above standards or the state's policies and procedures.



# References

Please return the completed training form  
to DCH at Fax: 404-463-2538

or

email [pecorrections@dch.ga.gov](mailto:pecorrections@dch.ga.gov)

or

<https://dch.georgia.gov/rsm-contact-information>

Click on RSM County Office

# References

Web Portal for the HPE Manual

Appendix I – Types of Income (included & excluded)

“Understanding Medicaid Booklet” order from WEB

<https://www.mmis.georgia.gov>

## How to 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 /DFCS



# Federally Facilitated Marketplace (FFM)

Applicants for health coverage in Georgia, who are childless adults between the ages of 19-64 years of age, should be guided to apply directly at the FFM to prevent any delay with their selection.

**HealthCare.gov**

<https://www.healthcare.gov>

Available 24/7 By Phone:

**1-800-318-2596**

TTY: 1-855-889-4325



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

# Provider Contact Center

Any provider related issues for enrollment , billing or claims contact: HP Provider Center

Call toll free 1-800-766-4456

Email: <https://www.mmis.georgia.gov/portal>

Use the Web Portal Contact feature



# Gloria D. Hill

Family Medicaid Program Consultant

Division of Medicaid

Georgia Department of Community Health

2 Peachtree St. NW, 39th Floor

Atlanta, GA 30303

404-463-0521 (phone)

770-344-4232 (fax)

[ghill1@dch.ga.gov](mailto:ghill1@dch.ga.gov)

