# Georgia Department of Community Health
# Request for Hardship Waiver of Application Fee

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

A request for a hardship waiver of the application fee shall be made at the time of submission of a Medicaid/PeachCare for Kids® enrollment or revalidation application using this form. Existing Medicaid providers who are requesting a waiver as part of revalidation shall upload a completed copy via the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov.

**For initial enrollment, applicants may upload the form via GAMMIS or attach the waiver with their application.** The Georgia Department of Community Health (DCH) will not process an enrollment application from a provider requesting a hardship waiver unless the application is accompanied by this form and until DCH has made a decision to approve the hardship waiver request. If the hardship waiver request is denied, the application will not be processed until payment is received.

**Existing providers and applicants who are requesting a hardship waiver must submit either their previous two (2) months' bank statements or the previous year's audited financial statements. Existing Medicaid providers who are requesting a waiver as part of revalidation shall attach the bank statements or financial statements with the waiver form as described above. For initial enrollment, applicants may either upload the bank statements or financial statements via GAMMIS or attach them with the waiver and include them with the enrollment application. For security purposes, DCH recommends that the provider or applicant redact account number(s) prior to submission.**

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| ATN (from revalidation or enrollment application, if applicable): | | Date Received: (Department Use Only) |
| Legal Business Name (from revalidation or enrollment application): * | | GA Medicaid Provider ID: |
| DBA Name (from revalidation or enrollment application): | | NPI: |
| Contact Name: * | Phone Number: * | Email Address: |

Describe the reason(s) below that you believe justifies the hardship waiver. Attach additional sheets, if necessary. *

## Provider's Attestation, Signature and Date

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance Plans for the purpose of requesting a waiver of the revalidation/enrollment application fee. I understand that falsification, omission or misrepresentation of any information in this form will result in a denial of my request for a waiver of the application fee. I authorize Medicaid or its authorized representative to verify this information.

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|---|---|
| Print Name * | Title * |
| Signature of Facility Administrator or Authorized Agent * | Date * |

* Required Field.

Rev. 01/2014