



Presumptive Eligibility (PE) WHM Medicaid



Presentation to: All Qualified Providers (QP) who determine Presumptive Eligibility (PE) Women's Health Medicaid.

Presented by: Memi Wilson, DCH Family Medicaid Consultant



Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

AGENDA

- Update: Congratulations to PE and BCCP Coordinators
- Update: Purpose of PE Coordinators
- Update: PE Medicaid Information
- Update: Qualified Immigrants
- Update: Qualified Immigrants Exempt
- Update: Refugee
- Update: Declaration of Immigration Status form 216
- PE WHM Manual
- PE Goal and Purpose
- Responsibilities of a QP
- Training Objectives
- Administration of the PE WHM Program

AGENDA (continued)

- PE Women's Health Medicaid
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- Conversion Factor
- FPL Chart
- PE WHM application approvals
- PE WHM application denials
- Smith family case
- GAMMIS



WHM Updates: PE Coordinators

(1-1) Rome

Carie Warren

(1-2) Dalton

Barbara Gibson

(2) Gainesville

Storie Allison

(3-1) Cobb

Rose Bishop

(3-2) Fulton

Debra Dewitt

(3-3) Clayton

Meko Ridley

(3-4) Gwinnett

Pam Austin

(3-5) DeKalb

Althea Otuata

(4) LaGrange

Amy Lane

WHM Updates: PE Coordinators

(5-1) Dublin

Teresa Carroll

(5-2) Macon

Ashley Rudeseal

(6) Augusta

Kathy Williams

(7) Columbus

Cathy Graves

(8-1) Valdosta

Maggie King

(8-1) Valdosta

Lisa Thomas

(8-2) Albany

Linda O'Donnell

(9-1) Coastal

Rebekah Chance-Revels

(9-2) Waycross

Kimberly Lee

(10) Athens

Kim McGinnis

WHM Updates: BCCP Coordinators

(1-1) Rome

Anne Murphy

(1-2) Dalton

Barbara Gibson

(2) Gainesville

Storie Allison

(3-1) Cobb

Cheri Holden

(3-2) Fulton

Debra DeWitt

(3-3) Clayton

Belinda Starks

(3-4) Gwinnett

Pam Austin and Karen Nixon

(3-5) DeKalb

Teresa Edwards

(4) LaGrange

Amy Lane

WHM Updates: BCCP Coordinators

(5-1) Dublin	Teresa Carroll
(5-2) Macon	Edge Tillman-Johnson
(6) Augusta	Jennifer Sapp
(7) Columbus	Tracey L. Hall
(8-1) Valdosta	Maggie King and Becky Owsley
(8-2) Albany	Linda O'Donnell
(9-1) Coastal	Rebekah Chance-Revels
(9-2) Waycross	Rebecca Brantley
(10) Athens	Pam Smith

WHM Updates: Purpose of PE Coordinators

Each District will have one PE Coordinator who will serve as the PE Medicaid contact. The PE Coordinator will distribute all the PE Medicaid information and request all PE Medicaid clearances for their District team.

WHM Updates: PE Medicaid Information

Distribution of PE Medicaid information includes:

- All DCH PE Medicaid MEMOs
- All revised/new PE Medicaid forms
- All DCH PE Medicaid BANNER Messages
- All PE Medicaid training material
- All DCH PE Medicaid clearances
- Prescription updates required same day
- GAMMIS glitches

Questions?

Before we move, on are there any questions regarding PE and BCCP Coordinators?

WHM Update: Qualified Immigrants

Two groups of Qualified Immigrants

1. Immigrants that have been in the United States for five (5) years per the Department of Homeland Security (DHS)
2. Immigrants that are exempt from the five (5) year bar per DHS

WHM Update: Qualified Immigrants Exempt

- 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).



WHM Update: Refugee

- 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.

Declaration of Immigration Status

Procedures

QP must have all applicants complete a Declaration of Citizenship/ Immigrant Status form 216 (Appendix F), as part of the PE WHM 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 WHM interview, copies should be made and one retained in the patient file and one faxed to ARROWHEAD with the PE WHM packet.

ADULT(S) SEEKING BENEFITS					
Name	Place of Birth (city, State, Country)	U.S. Citizen <small>(check whichever applies)</small>	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)

Form 216 ENG-SP Rev. 01/14

Questions?

Before we move, on are there any questions regarding Qualified Immigrants?

Questions?

Before we move on are there any questions regarding the PE WHM Updates?

For those only present for the updates return the Training Checklist form and sign in sheet by COB Monday to your designated PE Coordinator.

Document/Form	Title
PowerPoint	Presumptive Eligibility for WHM
DMA-632W	Presumptive Eligibility Application
Form 216	Citizenship Affidavit/Qualified Immigrant Status
DMA-634W	Notice of Action
DMA-285	Health Insurance Information Questionnaire
Medicaid Application	Medicaid Application Form 94 and how to order PE Forms
PE Document	Quick Guide on Women's Health Medicaid
PE Document	Procedures for processing On-line and Denied Applications
P4HB	Planning for Healthy Babies
UPDATES ONLY	



Presumptive Eligibility For Women's Health Medicaid (WHM) Manual

Information for this presentation is in the PE WHM Manual. To access this document, visit HP Enterprises website at:

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

NOTE: This manual is updated quarterly (January, April, July and October). It is recommended that you bring a copy of the most recent version of the PE manual with you to the training.

(Go to the Provider Information tab, Provider Manuals; manuals are in alphabetical order.)

Presumptive Eligibility Goal and Purpose

- **Goal**: Provide Medicaid coverage prior to the full Medicaid eligibility decision by ARROWHEAD Right from the Start Medicaid (ARSM) Project, and to remove barriers to the availability of breast and/or cervical cancer care and full Medicaid eligibility for all household members.
- **Purpose**: To allow an applicant to know immediately if she is eligible. If so, she can obtain breast and/or cervical cancer care at that moment.

Responsibilities of a Qualified Provider

- Make correct determinations of PE
- No back to back PE WHM applications
- Fax or email the PE WHM packet to ARSM daily (770 359 1813; womenshealth@dch.ga.gov)
- Enter the PE WHM approvals on the Web
- Assist the applicant with the signed Medicaid application form
- Inform the applicant in writing of the results of the PE determination
- Utilize PE Manual, trainings, and resources etc. to keep PE knowledge up to date

Presumptive Eligibility Objectives

Each Participant will...

- Understand the application process for Presumptive Eligibility
- Understand the eligibility requirements
- Be able to compute a Presumptive Eligibility budget using a PE WHM Application form DMA 632W
- Understand the process how PE becomes Full Medicaid

NOTE: PE WHM is not the same as BCCP.

Questions?

Before we move, on are there any questions regarding location of the PE WHM manual? PE WHM Goals and Purpose? Responsibilities of QPs? Our PE WHM training objectives?

Administration of the PE WHM Program

- Right to Apply
- Confidentiality of Information-HIPAA
- Nondiscrimination
- Notice
- Fair Hearing Rights
- Third Party Liability

Questions?

Before we move, on are there any questions regarding Administration of the PE WHM Program?

Presumptive Eligibility Women's Health Medicaid

- Available prior to a full Medicaid determination of eligibility made by the ARROWHEAD team.
- Begins the first day of the month eligibility is determined; prior months must be requested by the applicant (located on the Medicaid application).
- Covers all Medicaid services.
- Available only to applicants that meet the Breast and Cervical Cancer Program (BCCP) requirements. DPH is in charge of BCCP.

Presumptive Eligibility Women's Health Medicaid

- Family income must not exceed 200% FPL after allowable income disregards are given.
- Available to U.S. Citizens and Qualified Immigrants only. Emergency Medical Assistance (EMA) is not available in PE.
- Only Qualified Providers (QP) can make PE determinations; specialty code 278.

Presumptive Eligibility Women's Health Medicaid

- Must be a biological woman
- Under 65 years of age
- Not receiving Medicare regardless of age
- Not receiving Medicaid, except for P4HB 180-181
- Does not have private major medical insurance
 - Underinsured
- Must be a Georgia Resident
- At or below the 200% FPL limit

Questions?

Before we move, on are there any questions regarding PE WHM eligibility criteria?

Required Forms for PE Determinations

- DMA-632W - PE WHM Application
 - DMA 632W Page 2 (when required)
- 216 - Declaration of Citizenship/Immigration Status
 - Part of the 94 form
- DMA-634W - Notice of Action (*if appropriate)
 - Approval or Denial
- DMA-285 - Third Party Liability Questionnaire
 - Submit only if woman has private insurance. Copy of card not required, signatures in both areas required.

Required Forms for PE Determinations (cont.)

- Medicaid Application - Form 94
 - Do NOT use the Healthcare coverage application 94a
- HIPAA – Form 5460
 - Begin to use the new version once packets are delivered, until then continue to use the current one.
- Quick Guide for Women's Health Medicaid

NOTE: We will review each of these forms during the training please bring a copy.

How to Order PE Forms

- DMA 632W Application - The current application is located on the Web.
 - QP/QH will have to print the form after information has been entered on the fillable PDF form.
 - All approvals and denials are faxed to ARROWHEAD, DPH does not have a retention time frame for PE applications; however, DPH may want to keep a copy of the DMA 632W in the patient's file in case a copy is needed by DCH to expedite a correction to the case.
- DMA 632W Page 2 – The current page 2 is located on the Web.
 - This form is used with the DMA 632W application when additional room is required to list all the budget group members.

DMA 632W PE Application Form

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 _____ VALID FOR LISTED MONTH ONLY
PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAID			
APPLICANT'S NAME: _____ MAIDEN NAME: _____		HEALTH INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO	
APPLICANT'S ADDRESS: _____		TELEPHONE NUMBER: _____	
APARTMENT/LOT NUMBER: _____		SOCIAL SECURITY NUMBER: _____	
CITY: _____ STATE: _____		APPLICANT'S RECORD: _____	
ZIP CODE: _____		DATE OF INTERVIEW: _____	
COUNTY OF RESIDENCE: _____			

	FAMILY MEMBERS				DATE OF BIRTH MM/DD/YYYY	* RACE	GENDER	RELATION TO APPLICANT	MONTHLY GROSS INCOME				MONTHLY DISREGARDS		MONTHLY NET INCOME
	FIRST NAME	MI	LAST NAME	SUFFIX					TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	STANDARD WORK DISREGARD	DEPENDENT CARE DISREGARD	
01								SELF							
02															
03															
04															
05															
06															

SWORN STATEMENT OF APPLICANT:
 I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE ARROWHEAD RIGHT FROM THE START MEDICAID (ARSM) PROJECT WILL DETERMINE MY CONTINUING ELIGIBILITY.
 I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IN THE UNITED STATES AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY 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 ARSM MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY.
 I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS.

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.

DATE OF COMPLETION _____ COMPLETED BY (PLEASE PRINT) _____ TITLE _____

DIRECT PHONE NUMBER _____ SIGNATURE OF INDIVIDUAL COMPLETING FORM _____

TOTAL GROSS INCOME = _____ CHILD SUPPORT DISREGARD = _____ NUMBER IN FAMILY = _____ TOTAL FAMILY NET INCOME = _____ POVERTY INCOME LEVEL = _____
Applicant is <input type="checkbox"/> ELIGIBLE or <input type="checkbox"/> INELIGIBLE for PE WHM.
PROVIDER CERTIFICATION: I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN DETERMINED WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 106-354 ON _____ HER DIAGNOSIS MET THE BCC PROGRAM IN GEORGIA. I HAVE OBTAINED A SIGNED HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FAXED IT TO THE ARROWHEAD (ARSM) PROJECT AT 770-359-1813.
QUALIFIED PROVIDER SIGNATURE _____ TITLE _____ QUALIFIED PROVIDER NAME _____ QUALIFIED PROVIDER ID NUMBER _____ QUALIFIED PROVIDER ADDRESS: _____

632W (03/01/2014)



How to Order PE Forms (cont.)

- 216 Citizenship/Immigration Status - This form is not stocked.
 - This form is page 3 of the Medicaid form 94.
 - QP/QH should ask RSM or DFCS to give you these forms.
- DMA 285 TPL Questionnaire- Located on the Web.
 - To be used when a PE applicant has private insurance. Copy of the card is not required, only the top part of the form and both signatures/dates. This is the applicant's agreement to cooperate with TPL.

DMA 285 TPL Questionnaire

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH – THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE**

CASE NAME: _____ CASE NO: _____
 ADDRESS: _____ SSN: _____
 _____ PHONE NO: _____

TYPE OF CASE: INITIAL APPLICATION SPECIAL NEEDS TRUST (SNT) CHANGE CANCELLATION
 (Check all that apply) HIPPA REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION: ___/___/___

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 433.135-139). 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 type="checkbox"/> NO	Is policyholder an Absent Parent? <input type="checkbox"/> YES <input 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 type="checkbox"/> YES <input type="checkbox"/> NO	

Names of Covered Individuals in Household			Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
Last	First	(MI)			Policy Holder	Spouse	Child	Step-child	Other	

Are any of these persons pregnant? YES NO If yes, Name _____ Date of Delivery _____

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 type="checkbox"/> NO If yes, Name _____ Condition _____
---	--

(Insurance Company Name) _____ (Telephone Number) _____
 (Address) _____ (City) _____ (State) _____ (Zip) _____
 (Policyholder Name) _____ (Policyholder SSN) _____ (Policy Number) _____ (Policyholder DOB) _____
 (Policy Effective Date) _____ (Policy Termination Date) _____
 (Employer Name) _____ (Telephone Number) _____
 (Employer Address) _____ (City) _____ (State) _____ (Zip) _____

Types of Coverage (circle those which apply)	
01 – HOSPITAL INPT.	15 – LTC/NH
07 – DRUG/STND	16 – FMO/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 _____ Date _____ Signed _____ Date _____
 Member or Authorized Person Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY _____

Case Worker Name: _____ Phone No: _____ County _____

DMA-285-REV. (01/06)

How to Order PE Forms (cont.)

- Medicaid Application- www.odis.dhr.state.ga.us
 - Click index, Family & Children, Medicaid, MAN3480, Appendix F, Form DHS 94
 - You may also ask RSM or DFCS to give you these applications.
 - Available in both English and Spanish.
- HIPAA- www.odis.dhr.state.ga.us
 - Click index, Family & Children, Medicaid, MAN3480, Appendix F, Form DHS 5460
 - You may also ask RSM or DFCS to give you these forms.
 - Available in both English and Spanish.

Medicaid Application form 94

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept

We will consider this application without regard to race, color, sex, age, disability, religion, national origin or political belief.

Check block(s) that apply to you:
 Pregnant Woman
 Families w/ Children - LHM
 Child(ren) Only - RSM
 Chafee Independence Program-Medicaid
 Were you in foster care on your 18th birthday? Yes No In which state? _____

Please answer all questions as completely and accurately as possible. If you cannot understand or complete this form, please call 1-800-368-8888.

Today's Date: _____
 State: _____ Zip Code: _____
 E-mail Address: _____

Mailing Address: _____
 Residence Address (if different from Mailing Address): _____
 Phone Number(s): _____

Please list all persons living with you for whom you want Medicaid. List yourself if you want Medicaid for yourself.

First Name	MI	Last Name	Suffix (Jr)	Race	Sex M/F	Date of Birth	Relationship to You	Social Security Number	In this Person a U.S. Citizen? (Y/N)	Does the Father of this child live in your home? (Y/N)

Please list all persons living with you for whom you DON'T want Medicaid. List yourself if you don't want Medicaid. You do not have to provide a SSN or immigration status information with the Department of Homeland Security (formerly the INS).

Is anyone in the household pregnant? Yes No If yes, who is pregnant? _____
 Do you have any unpaid medical bills from the past three months? Yes No If yes, which months? _____
 Does anyone in your household have Health Insurance? Yes No If yes, list insurance Company and policy number: _____
 Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? Yes No If yes, have you received Women's Health Medication? Yes No

INCOME, RESOURCES and DEPENDENT CARE

List all income received by persons on page 1 of this application. Be sure to show the amount before deductions. Attach an extra sheet if necessary. We will decide, based on the type of Medicaid, whose income must be counted and whose may be excluded. If you are applying for Children Only or Pregnant Woman Medicaid, you do not have to complete the Resources/Vehicles section below.

Income	Gross Amount per Pay Check (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving	Resources	Amount in Account/Value	Who Owns Resource?
Wages/Earnings				Cash		
Current Employer:				Checking Account		
Wages/Earnings				Savings Account		
Current Employer:				Credit Union		
Social Security Income/SSI				401K/Retirement Account		
Worker's Compensation				Other		
Pensions or Retirement Benefits				Vehicle(s): Cars, trucks, motorcycles (licensed)		
Child Support/Contributions				Make	Model	Year
Unemployment Benefits						Amount Owned?
Other Income, please specify:						

Do you pay for dependent care (day care for a child or care for an adult who cannot care for himself/herself) so that someone in your household can work?

Name of Parent who works	Name of child or adult cared for	Name of care provider	Amount of Payment	How Often? (weekly, 2-weeks, monthly, etc)

If you are applying for Medicaid for children and one or both of their parents are not in the home, please provide the following information:

Child's Name	Absent Parent's Name (Mother/Father)	Do they have Medical Coverage on the Child? Yes/No	If Yes to Medical Coverage, please list name of insurance company & group number

I understand that this information may need to be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be obtained to verify and determine eligibility for Medicaid. I agree to assign to the state all rights to medical support and third party support payments (hospital and medical benefits). I agree to give the State the right to require an absent parent provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do not cooperate, I understand I may lose my Medicaid benefits, and only my children will receive benefits unless good cause is established. I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.
 I declare under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States. If I am a parent or legal guardian, I declare that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States. I declare to the best of my knowledge and belief that the person(s) for whom I am applying for Medicaid is/are U.S. citizen(s) or are lawfully present in the United States. I further certify under penalty of perjury that all of the information provided on this application is true and correct to the best of my knowledge.

Signature (Required): _____ Date: _____
 Form 94 (10/12)

How to Order PE Forms (cont.)

- DMA 634W Notice of Action - Located on the Web.
 - DMA 634W Approval – to be used when the temporary Medicaid Certificate does not print for approved PE WHM beneficiaries.
 - DMA 634W Denial – to be used to notify the PE applicant the PE application was denied.
 - Both DMA 634W forms are fillable PDF.
- Quick Guide on Medicaid for WHM– Located on the Web.
 - To be given to all approved PE WHM approvals.
- All Planning for Healthy Babies materials are no longer available. The program is still active until 6/30/14, and DCH is waiting on CMS approval for an extension. Refer applicants to www.p4hb.org



DMA 634W Notice of Action

 **GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

Nathan Deal, Governor Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

NOTICE OF ACTION
Presumptive Eligibility for Women's Health Medicaid

Date

Name

Address

City State GA Zip Code

A. PRESUMPTIVE ELIGIBILITY APPROVED:
Medicaid ID Number

Your application for Presumptive Eligibility for Women's Health Medicaid is approved.

When you applied for PE Women's Health Medicaid, you may also have applied for Healthcare coverage. The Healthcare coverage application will be sent to the ARROWHEAD Right from the Start Medicaid (ARSM) Project. ARSM will make the decision for your regular Medicaid benefits and notify you by mail.

This Medicaid coverage provides all Medicaid services. Your presumptive eligibility coverage ends when a final determination of eligibility is made by the ARSM office.

Signature of Qualified Provider
Title Phone Number Qualified Provider ID

DMA 634W Approval (Revised 4/1/14)

Health Information Technology | Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan
Equal Opportunity Employer

 **GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

Nathan Deal, Governor Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

NOTICE OF ACTION
Presumptive Eligibility for Women's Health Medicaid

Date

Name

Address

City State Zip Code

B. PRESUMPTIVE ELIGIBILITY DENIED:

Your application for Presumptive Eligibility for Women's Health Medicaid is denied.

The reason for denial is:

When you applied for PE Women's Health Medicaid, you may also have applied for Healthcare coverage. The Healthcare coverage application will be sent to the ARROWHEAD Right from the Start Medicaid (ARSM) Project. ARSM will make the decision for your regular Medicaid benefits and notify you by mail. ARSM 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
Title Phone Number Qualified Provider ID

DMA 634W Denial (Revised 4/1/14)

Health Information Technology | Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan
Equal Opportunity Employer

Quick Guide on Medicaid for WHM



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

Quick Guide on Women's Health Medicaid

Some important things to know about Women's Health Medicaid (WHM) coverage:

- When you applied for PE Women's Health Medicaid, you may also have applied for Healthcare coverage. The Healthcare coverage application will be sent to the ARROWHEAD Right from the Start Medicaid (ARSM) Project. ARSM will make the decision for your regular Medicaid benefits and notify you by mail. You will be assigned an ARSM Medicaid Specialist. This caseworker may contact you for additional information.
- If approved, Medicaid will cover you as long as you are in cancer treatment and you continue to meet the eligibility requirements. There are other types of Medicaid that may cover you after that point.
- 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.
- You must call your ARSM Medicaid Specialist, at _____, within 10 days of **all** household changes; especially if your cancer treatment has ended.
- You will have a yearly renewal in your birth month. Income verification is required. Your net income must be at or below 200% of the Federal Poverty Level (FPL) to potentially remain eligible for WHM
- The month you turn 65 years of age is the last month you will be potentially eligible for WHM since you will be eligible for Medicare. Please prepare for this change so you are not without coverage. Any questions regarding Medicare can be answered by contacting Medicare at 1-800-MEDICARE (1-800-633-4227); TTY 1-877-486-2048 or www.Medicare.gov
- If you need a replacement Medicaid card call Member Contact Center at 1-866-211-0950.
- If you have questions about what Medicaid covers, ask your doctor or call: 1-866-211-0950.

Revised (4/1/14)

Health Information Technology | Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan

Equal Opportunity Employer



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Questions?

Before we move, on are there any questions regarding PE WHM forms?

Non-Financial Components

Who To Include In The Budget Group (BG)

- Applicant is a BG of one at a minimum.
- Spouse of the applicant and their child(ren).
- If not married but have at least one common child, add other parent.
- Non stepchild(ren) of the applicant living in the home if she wants them added.

Who Not To Include In The Budget Group

- Other Parent's children.
- Spouse's children.
- Other relatives living in the home-
parents, siblings, nieces, cousins, etc.
 - Specified Relative Relationship
- Child(ren) 19 years of age or older.
- Child and/or spouse, living in the home who are receiving SSI (Supplemental Security Income).

BUDGET GROUP EXCLUSION

- In order for a child to be included in the budget group, he/she must be the child of the applicant to be included in the budget group. However, the applicant can elect to exclude a child(ren) because of income designated solely for the child(ren). If the applicant elects to exclude the child, the child and his/her income are not included in the applicant's budget group.
- Do not include Step Child(ren) in the budget group.

Budget Group Exclusion Example

Barbara Stevenson applies for PE WHM. She lives with her daughter Janet Brown (14), her son Robert Williams (16), and her stepson Marcus Jackson (12).

Barbara's wages = \$2,016 gross monthly

Janet's child support = \$747 monthly

Robert's RSDI = \$1,114 monthly

Marcus doesn't have any income

Budget	200%
Group	FPL
1	1946
2	2622
3	3300
4	3976

Budget Group Exclusion Example (cont.)

Household members = 4

Maximum BG members = 3 why?

BG 3 (Barbara, Janet and Robert) = $\$3,877 - \$90 = \$3,787 - \$50 = \$3,737$

BG 2 (Barbara and Robert) = $\$3,130 - \$90 = \$3,040$

BG 2 (Barbara and Janet) = $\$2,763 - \$90 = \$2,673 - \$50 = \$2,623$

BG 1 (Barbara) = $\$2,016 - \$90 = \$1,926$

Questions?

Before we move, on are there any questions regarding PE WHM Budget Groups?

FINANCIAL COMPONENT

Income is defined as money received by the budget group from any source. All income must be examined in determining Presumptive Eligibility.

The budget group's net monthly income must be less than or equal to the federal income poverty level limit of 200%.

- Types of Income: Earned and Unearned

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. For budgetary purposes, certain disregards are applied to earned income.
- **Unearned Income**---is money received for reasons other than for services rendered. It may be in the form of pensions, contributions, gifts (monetary), child-support, unemployment insurance, strike benefits, or interest payments. Except for child-support, no disregards are applied to unearned income.



SELF EMPLOYMENT INCOME

- For self-employment income, gross income is considered to be the total profit from the business. Net income is determined by deducting business expenses (those costs directly related to producing goods or services) from the gross income. The net income amount may receive the \$90 work disregard if the person is performing self-employment activities.

Not Counted

- When an individual receives food, shelter, clothing, or some alternative payment other than cash for performing work activities, the value of these items is not considered when determining financial eligibility.
- The earned income of an applicant's child under 19 years old is not included. In situations of this nature, show the child in the applicant's budget group but do not show the earnings.

SOME EXEMPT INCOME TYPES

- Adoption Assistance or Foster Care
- TANF (Temporary Assistance to Needy Families) Payments
- Food Stamps
- Supplemental Security Income (SSI)
- Disaster Relief Assistance
- Earned Income Tax Credits
- Energy Assistance Payments
- Educational Grants, Loans, and Scholarships **Note:** Income received from these sources is not included in any budget calculations to determine PE WHM. Under federal statute, they have been defined as excludable.
- Wages from temporary employment with the Census Bureau.
- Stimulus income

Questions?

Before we move, on are there any questions regarding PE WHM Financial Components?

Disregards

- Unearned Income---\$50.00 Child-Support Disregard: This is the only disregard allowed for unearned income.
- Earned Income---\$90.00 Standard Work Expense (per employed adult budget group member)
- Dependent Care Expenses- Allowed if employed person pays.
- Maximum of \$200.00, per month, for each individual under 2. Maximum of \$175.00, per month, for each individual over 2.

CONVERSION FACTOR

IF PAID

- HOURLY
- WEEKLY
- BI-WEEKLY
- SEMI-MONTHLY
- YEARLY

THEN MULTIPLY BY

NUMBER OF HOURS
WORKED PER WEEK X
(TIMES) THE HOURLY
WAGE X 4.3333 WEEKS

WEEKLY GROSS INCOME X 4.3333

BI-WEEKLY GROSS INCOME X 2.1666

SEMI-MONTHLY GROSS INCOME X 2

DIVIDE THE YEARLY GROSS INCOME X 12

FEDERAL POVERTY LEVEL (FPL) LIMITS

Effective April 1, 2014 (Remain 200%)

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.

Questions?

Before we move, on are there any questions regarding PE WHM Income? PE WHM Disregards? PE WHM Conversion Factors? PE WHM FPL Chart?

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

701 On-Line Procedures

- The on-line process allows certain information contained on the completed PE WHM application (form DMA 632W) 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 BCCP 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 WHM application form DMA 632W is involved in the automated process.



701.1 PE WHM Approvals

Only information from approved PE WHM applications can be entered into the GAMMIS system. The completed PE WHM application (DMA 632W) 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 WHM Medicaid, adhere to the following procedures:

- Data enter in the appropriate fields certain demographic information contained on the application. When processing over the Internet, the beneficiary'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
- If all data are entered correctly, the system will allow production of a temporary Medicaid certificate. Print out two copies of this document.

701.1 PE WHM Approvals (continued)

- Give the applicant a copy of the temporary Medicaid certificate. In addition to serving as a temporary Medicaid certificate, this document serves as a notice to the applicant that she is approved for Medicaid.

For the on-line process, if the temporary Medicaid certificate is not printed, use the **Notice of Action, form DMA 634W Approval**. Instruct the applicant to present this document to her providers as proof of Medicaid eligibility.

- Retain a copy of the temporary Medicaid certificate/DMA 643W Approval in the record, along with the PE WHM application DMA 632W.
- The same day the PE WHM application is completed, fax the PE WHM packet to the ARSM office. The ARSM team will review the beneficiary's eligibility for ongoing and retroactive Medicaid (if requested).

Approved PE WHM Packets Include

- Form 632W
- DMA 285, if required
- Form 634W Approval (for manually updated approval only)
- HIPAA
- Medicaid Application form 94
- Declaration of Citizenship/Immigration Status form 216 (if not included with form 94)
- Certificate of Diagnosis

Questions?

Before we move, on are there any questions regarding PE WHM Approvals?

703 Denied PE WHM Applications

- When the PE WHM 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 does not meet the BCCP. 3) The applicant's net family income is above 200% of the federal poverty level limit. 4) The applicant is 65 years of age or older. 5) The applicant has Medicaid and/or Medicare. 6) The applicant is not underinsured. 7) The applicant is not a Georgia Resident.



703 Denied PE WHM Applications (continued)

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

- Complete and give the applicant a copy of the **Notice of Action, DMA 634W Denial**. In the case of a denial, this is the **only** form the applicant receives.
- The same day the PE WHM application is completed, fax or scan/email, the PE WHM packet to the ARSM office.

Denied PE WHM Packets Include:

- Form 632W
- Form 634W Denial
- DMA 285, if required
- HIPAA
- Medicaid Application form 94
- Declaration of Citizenship/Immigration Status form 216 (if not included with form 94)
- Certificate of Diagnosis

Questions?

Before we move, on are there any questions regarding PE WHM Denials?

Smith Family Case PE WHM Example

Mrs. Smith has met the BCCP requirement.

She lives with her two daughters, Jane, 9 years old, and Debbie, 13 years old.

Mrs. Smith is separated from her husband who pays \$100, per month, child support for their daughter, Jane.

Debbie, Mrs. Smith's daughter from a previous marriage, receives \$150 per month child support from her absent father.

Mrs. Smith earns \$725.00 per week at Wilson's Appliances.

Smith Family Case – Exclude Children

If Mrs. Smith chooses to exclude both children:

\$ 3141.64	Mrs. Smith's earned income
<u>\$ -90.00</u>	Standard work expense disregard
\$ 3051.64	Total net income for BG of 1

BG of 1 income limit = \$1,946

Not PE eligible for a BG of 1

Smith Family Case –Include Children

If Mrs. Smith chooses to include the children:

\$ 3141.64	Mrs. Smith's earned income
<u>\$ -90.00</u>	Standard work expense disregard
\$ 3051.64	
<u>\$ 100.00</u>	Child support received for Jane
\$ 3151.64	
<u>\$ 150.00</u>	Child support received for Debbie
\$ 3301.64	
<u>\$ -50.00</u>	Child support disregard
\$ 3251.64	Total net income

BG of 3 income limit = \$3,300

PE eligible for a BG of 3

Unearned Income Disregard

Remember Medicaid policy only allows one child support disregard per BG regardless of how many different types of child support payments the household receives monthly.

This BG receives two different monthly child support payments; however, only one \$50 deduction is allowed.

If the total child support payment is equal to \$50 a month, then the total child support amount to count in the budget is zero.

If the total child support payment is less than \$50 then count up to that amount as the disregard.

Child support is the only unearned income that is allowed a disregard.

Ms. Smith's PE Application Form DMA 634W

EFFECTIVE FOR SERVICES BEGINNING April 1, 20XX
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



1112223344555
 MEDICAID IDENTIFICATION NUMBER

April 1- May 31, 20XX
 VALID FOR LISTED MONTH ONLY

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAID

APPLICANT'S NAME: L.H. Smith MAIDEN NAME: Brown HEALTH INSURANCE: YES NO

APPLICANT'S ADDRESS: 34 First Avenue TELEPHONE NUMBER: (404) 555-1212

APARTMENT/LOT NUMBER: #2A SOCIAL SECURITY NUMBER: 123-45-6789 APPLICANT'S RECORD: ABC123
(Optional)

CITY: Atlanta STATE: GA ZIP CODE: 30303 COUNTY OF RESIDENCE: Fulton 060 DATE OF INTERVIEW: 5/1/20XX

	FAMILY MEMBERS			DATE OF BIRTH MM/DD/YYYY	* RACE	GENDER	RELATION TO APPLICANT	MONTHLY GROSS INCOME			MONTHLY DISREGARDS		MONTHLY NET INCOME	
	FIRST NAME MI	LAST NAME	SUFFIX					TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	STANDARD WORK DISREGARD		DEPENDENT CARE DISREGARD
01	L.H.	Smith		05/19/97	H	F	SELF	W	725	WK	3141.64	90	0	3051.64
02	Jane G.	Smith		04/01/00	W	F	Daughter	OU	100	MO	100			100
03	Debbie J.	Smith		11/29/01	B	F	Child	OU	150	MO	150			150
04														
05														
06														

SWORN STATEMENT OF APPLICANT:
 I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE ARROWHEAD RIGHT FROM THE START MEDICAID (ARSM) PROJECT WILL DETERMINE MY CONTINUING ELIGIBILITY.
 I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IN THE UNITED STATES AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY 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 ARSM MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY.
 I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS.

DATE OF APPLICATION: 4/30/XX APPLICANT'S SIGNATURE: L.H. Smith

*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.

DATE OF COMPLETION: 5/1/XX COMPLETED BY (PLEASE PRINT): Memi Wilson TITLE: MD

DIRECT PHONE NUMBER: (404) 463-0521 SIGNATURE OF INDIVIDUAL COMPLETING FORM: Memi Wilson

632W (03/01/2014)

TOTAL GROSS INCOME = 3391.64 CHILD SUPPORT DISREGARD = 50
 NUMBER IN FAMILY = 3
 POVERTY INCOME LEVEL = 3300.00 TOTAL FAMILY NET INCOME = 3251.64

Applicant is ELIGIBLE or INELIGIBLE for PE WHM.

PROVIDER CERTIFICATION:
 I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN DETERMINED WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 106-354 ON 1/17/XX.
 HER DIAGNOSIS MET THE BCC PROGRAM IN GEORGIA. I HAVE OBTAINED A SIGNED HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FAXED IT TO THE ARROWHEAD (ARSM) PROJECT AT 770-359-1813.

QUALIFIED PROVIDER SIGNATURE: Memi Wilson TITLE: Doctor

Full Provider Name Here: Memi Wilson Provider ID Number Here: _____
 QUALIFIED PROVIDER NAME: _____ QUALIFIED PROVIDER ID NUMBER: _____

QUALIFIED PROVIDER ADDRESS: Provider Street Address Here
Provider City, State, Zip Code Here



Questions?

Before we move, on are there any questions regarding the Smith Family's PE WHM application?

Screen on GAMMIS

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 | GBHC Referral | Reports | Trade Files
 Home | Eligibility Request

User Information - Provider 000006707D ?

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.

Pregnant Women receiving Medicaid are exempt from copays from the 1st day of pregnancy until the end of the month of the 60 day transitional period.

The following messages were generated:

Message Description	Panel	Field	Row
No match using search criteria SSN: 123456789, Name: SMITH, L.H.	Eligibility Verification Request		

Eligibility Verification Request ?

Member ID	<input type="text"/>	Birth Date	<input type="text"/>	<input type="button" value="C"/>
Last Name	SMITH	SSN	123-45-6789	
First Name	L.H.	From/Thru Date of Service	<input type="text"/>	<input type="button" value="C"/> <input type="button" value="C"/>
Gender	Female			<input type="button" value="search"/> <input type="button" value="clear"/>

Blank PE WHM Panel

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 | GBHC Referral | Reports | Trade Files
Home | Newborn Activations | Pregnant Women Activations | **Women's Health Activations**

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 Women's Health Care Request

Member Info

Member ID
First Name*
Last Name*
MI
Suffix
Birth Date*
SSN

Mailing Address

Address*
Address 2
City*
Zip*
State*
County*

Residential Address

Same as Mailing Address
Address*
Address 2
City*
Zip*
State*
County*

Other Member Information

Home Phone
Other Phone
Race*
Ethnicity*
Citizenship*
Eligibility Begin Date*
Primary Household Language*



Member ID Function

Presumptive Eligibility for Women's Health Care Request ?

Member Info

Member ID

First Name*

Last Name*

Birth Date* 

SSN

Windows Internet Explorer

 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.

OK

City*

Zip*

State* GA 

County*

Application Date

Presumptive Eligibility for Women's Health Care Request

Member Info

Member ID

First Name*

Last Name*

MI

Suffix

Mailing Address

Address*

Address 2

City*

Zip*

Residential Address

Same as Mailing Address

Address

Address 2

City

Zip

Other Member Information

Home Phone

Other Phone

Race*

Ethnicity*

Citizenship*

Birth Date*

SSN

State*

County*

Eligibility Begin Date*

Primary Household Language*

Calendar - Windows Internet E...

https://www.betammis.georgia...

April 2014						
Su	Mo	Tu	We	Th	Fr	Sa
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	1	2	3
4	5	6	7	8	9	10

Error Message for PE WHM in GAMMIS

The following messages were generated:

Member found on file with current eligibility. Request cannot be processed

Presumptive Eligibility for Women's Health Care Request



What does this error message mean?

Why would this error message be received?

What are the next steps?

Confirmation

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 11122233344. 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 Women's Health Care Request ?

Member Info

Member ID

First Name

Last Name

MI

Suffix

Birth Date

SSN

Temporary Medicaid Certificate -Top

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: 001553

Temporary Medicaid Certificate -Middle

Eligibility Verification Request ?

From/Thru Date of Service: 04/01/201 - 05/31/201
 Service Type: 30 - Health Plan Benefit Coverage

Member ID Information ?

Member ID	[REDACTED]	First Name	L
Birth Date	05/19/197	Last Name	SMITH
Address 1	2A 1ST AVE NE # 34	Middle Initial	H
Address 2(County)	060 - FULTON	Name Suffix	
City	ATLANTA	Gender	F
State	GA	Transaction Date/Time	05/01/201 09:43:24
Zip	30317-2647	Confirmation #	141 00E

Benefit Plans ?

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	MEDICAID

Temporary Medicaid Certificate -Bottom

Eligibility by Service Type



Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	1 - Medical Care	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Inactive for Service Type Code selected.	33 - Chiropractic	04/01/201	05/31/201				
Active	35 - Dental Care	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	47 - Hospital	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	48 - Hospital - Inpatient	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	50 - Hospital - Outpatient	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	86 - Emergency Services	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	88 - Pharmacy	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	98 - Professional (Physician) Visit - Office	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	AL - Vision (Optometry)	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	MH - Mental Health	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	
Active	UC - Urgent Care	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	0.00	

Retroactive Eligibility



Retroactive Begin Date	Retroactive End Date	Retroactive Eff (Update) Date
04/01/201	04/30/201	05/01/201



Screened on GAMMIS after completion

Eligibility Verification Request ?

Member ID	<input type="text"/>	Birth Date	<input type="text"/>	<input type="button" value="v"/>
Last Name	<input type="text"/>	SSN	<input type="text"/>	
First Name	<input type="text"/>	From/Thru Date of Service	<input type="text" value="03/31/201"/>	<input type="button" value="v"/> <input type="text" value="05/31/201"/> <input type="button" value="v"/>
Gender	<input type="button" value="v"/>	Service Type	30 - Health Plan Benefit Coverage <input type="button" value="v"/>	

Member ID Information ?

Member ID	<input type="text"/>	First Name	L
Birth Date	05/19/197	Last Name	SMITH
Address 1	2A 1ST AVE NE #34	Middle Initial	H
Address 2(County)	060 - FULTON	Name Suffix	
City	ATLANTA	Gender	F
State	GA	Transaction Date/Time	05/01/201 12:39:56
Zip	30317-2647	Confirmation #	141210 <input type="text"/>

Benefit Plans ?

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	04/01/201	05/31/201	MC - Medicaid	800 - Presumptive BCC	MEDICAID

Questions?



WHM?

Huh??

Got me!



BCCP?



Memi Wilson

Family Medicaid Program Consultant

Division of Medical Assistance Plans

Georgia Department of Community Health

2 Peachtree St. NW, 39th Floor

Atlanta, GA 30303

404-463-0521 (phone)

770-344-4232 (fax)

mwilson@dch.ga.gov