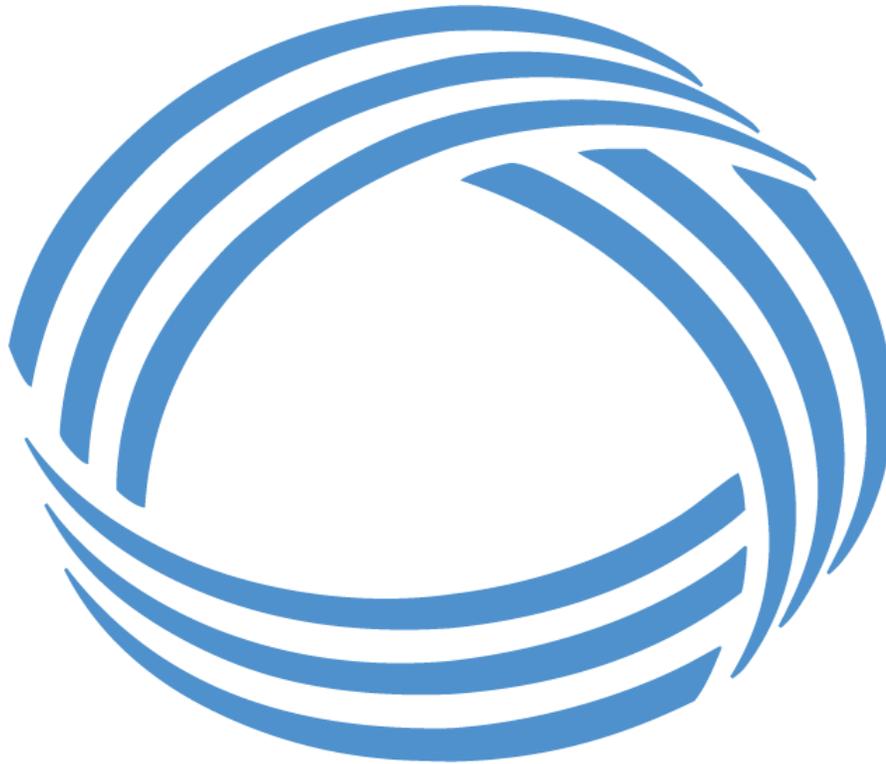


PART II
POLICIES AND PROCEDURES
FOR
AFFORDABLE CARE ACT
QUALIFIED HOSPITALS
FOR PRESUMPTIVE ELIGIBILITY
PARENT/CARETAKER WITH CHILD (REN)
CHILDREN UNDER THE AGE OF 19
FORMER FOSTERCARE



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: July 1, 2016

**PART II- POLICIES AND PROCEDURES
AFFORDABLE CARE ACT QUALIFIED HOSPITALS
FOR PRESUMPTIVE ELIGIBILITY
PARENT/CARETAKER WITH CHILD (REN), CHILDREN UNDER THE AGE
OF 19, FORMER FOSTERCARE CONTENTS**

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CHAPTER 100 INTRODUCTION

101 Goal of Presumptive Eligibility (PE)

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

The Department of Community Health (DCH) is committed to providing qualified hospitals for determining a PE Parent/Caretaker with Child(ren), Children Under the Age of 19, Pregnant Woman, and Former FosterCare with clear and practical guidelines to:

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

**PE Women's Health Medicaid- refers to the PE WHM manual for regulations, forms and procedures.

Form 632H can be used for PE Pregnant Women Medicaid- refer the PE Pregnant Women Medicaid manual for complete regulations and procedures.

CHAPTER 200 OVERVIEW OF PRESUMPTIVE ELIGIBILITY

201 Definition and Description of Presumptive Eligibility (PE)

§435.907 Application; §435.1103 Presumptive eligibility for other individuals/SPA
ATTACHMENT 22-A Page 23B

PE is an expedited process of enrolling eligible applicants into the Medicaid program, who are determined by a qualified hospital (QH), on the basis of preliminary information, to be presumptively eligible.

Medicaid coverage is available prior to a formal determination of eligibility by the local Right from the Start Medicaid (RSM) or Division of Family and Children Services (DFCS) team.

Medicaid coverage may be granted to the applicant who meets the eligibility requirements consisting of an income comparison test using the applicant's statements to establish gross income and pregnancy.

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

If the applicant is determined eligible for the program, the individual(s) receive a temporary Medicaid certificate for their first month of eligibility. If the eligibility continues, the individual(s) receive the plastic Medicaid member identification card.

The number for that card is in the same format as other Medicaid identification numbers. This number will remain the same throughout the member's eligibility.

PE determinations for Parent/Caretaker with Child(ren), Children Under the Age of 19 and Former FosterCare can be completed by QHs only. RSM and DFCS are not included in the legislation as qualified hospitals.

A qualified hospital is a hospital that:

- (1) Participates as a Georgia Medicaid provider;
- (2) Notifies DCH of its election to make PE determinations;
- (3) Agrees to make PE determinations consistent with DCH's policies and procedures;

- (4) Assists individuals in completing and submitting the full single streamlined application and understanding any documentation requirements; and
- (5) Has not been disqualified by DCH.

As part of the PE process, the QH will complete and fax to DCH at 404-463-2538, or scan the complete PE packet to pecorrections@dch.ga.gov within five (5) calendar days of the PE completion regardless if the PE application was approved or denied.

202 Summary of Process

The PE process involves the qualified hospital (QH), the Department of Community Health (DCH), the Georgia Medicaid Management Information System (GAMMIS), and RSM/DFCS teams. The QH determines eligibility for the presumptive period, the RSM/DFCS team determines eligibility for ongoing and retroactive Medicaid; and DCH/GAMMIS issues the Medicaid member card and provides reimbursement to participating providers for Medicaid approved services.

The process begins when the applicant enters the QH's office and requests Medicaid coverage. The QH obtains enough information to determine income eligibility and established the individual(s) qualify for PE Medicaid. Additionally, the QH assists the applicant in completing a single streamlined application for ongoing and retroactive Medicaid eligibility.

After the PE application is approved, the eligible member is given a temporary Medicaid certificate. The QH will fax the completed PE application packet to DCH. Upon receipt of the PE packet, DCH will review for accuracy; intervening when errors or abnormalities are observed by notifying the QH of any incorrect policy and/or procedures. DCH will email the RSM office the PE packet. RSM/DFCS registers the Medicaid application and determines eligibility for ongoing months, as well as the retroactive months when requested. Notice is given to the member regarding the eligibility finding, and the results of the determination are forwarded to the DCH/GAMMIS for appropriate processing.

When DCH/GAMMIS receives the eligibility information, an open record is established for the member for payment of claims. When the DCH/GAMMIS is notified by the RSM/DFCS teams of the results of the Medicaid

determination, the record is continued as an active Medicaid record if eligible or the PE is closed if ineligible.

203 Certification Process and Liability

Per the Affordable Care Act (ACA), hospitals who meet the requirements of participation will be given the opportunity to become qualified hospitals (QH) by competing PE Medicaid training. The training requirement is met by attending a presumptive workshop and satisfactorily performing the training exercises.

Upon completion of the training, each hospital certifies that all QH requirements have been met by completing the QH enrollment form. 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.

A hospital interested in becoming a QH should contact:

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

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

Enrollment Wizard

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

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

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

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

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

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

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

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

[Provider Enrollment Application](#)

203.1 Disqualification of hospitals

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.

204 Responsibilities of a Qualified Hospital

- Make correct determinations of PE Medicaid;
- Fax DCH at 404-463-2538, or scan the complete PE Medicaid packet to pecorrections@dch.ga.gov. within five (5) calendar days of the PE determination results;
- Assist the applicant complete a signed single streamlined Medicaid application;
- Inform the applicant in writing of the results of the PE Medicaid determination;

2015 Hospital Presumptive Training Schedule

Revised
01/01/16

Future training dates to be announced

If you have any questions about these training dates, please contact pecorrections@dch.ga.gov

QHs may also contact DPH to reserve seating for the VICS training.

CHAPTER 300 GENERAL PROGRAM REQUIREMENTS

301 Right to Apply

§435.906 Opportunity to apply.

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

A PE Medicaid application may be made at any time even if there is a Medicaid application pending at the county DFCS office; however, PE applications cannot be completed for individuals that are receiving full Medicaid benefits or after the termination of pregnancy.

If the applicant is already active on another Medicaid class of assistance (COA), inform the applicant they are already active. PE is a temporary Medicaid; therefore, do not complete a PE Medicaid application when the applicant is already active on full Medicaid except for Planning for Healthy Babies (P4HB) aid categories 180-181 or Qualified Medicare Beneficiaries (Q-Track) aid categories 660,661,662. Refer to appendix C for a brief overview of the COA.

If the member is active on Planning for Healthy Babies (P4HB) or Q-Track complete the PE Medicaid application and GAMMIS will update the system.

The applicant is the primary source of information regarding PE. The QH will make the determination of eligibility based solely on the information obtained in the interview and will not require any verification or documentation of the applicant's statements.

PE policy does not allow for Emergency Medical Assistance (EMA) to be approved as PE. An applicant may not be refused a PE application if they are not a United States citizen; have not be naturalized; or have not been in the United States for at least 5 years per the Department of Homeland Security (DHS).

These applicants will be given an application form 632H and informed that their PE application will be denied initially; however, the Medicaid application will be reviewed by the RSM/DFCS team and the applicant will be notified of the final disposition of the Medicaid application for EMA.

302 Confidentiality

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

DCH, RSM, DFCS, QH, MAXIMUS are covered entities.

Who is affected by HIPAA?

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

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

More information on covered entities can be found at:

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

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

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

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

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

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

Each applicant will receive the Notice of Privacy Practices Form.

HIPAA resource information can be found at:

<http://dch.georgia.gov/hipaa-privacy-notices>

303 Non-Discrimination

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

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

304 Notice and Informing

§435.913 Notice of agency's decision concerning eligibility.

An applicant is entitled to adequate notice of the results of the PE determination. They must receive notice that their application for Medicaid

has been forwarded to the RSM/DFCS for a formal determination of eligibility.

Follow the process outlined in Chapter 700 for approvals or denials.

305 Fair Hearing Rights

§431.205 Provision of hearing system.

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

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

307 Planning for Healthy Babies (P4HB)

The Planning for Healthy Babies (P4HB) waiver covers Family Planning services to women ages 18 through 44 who are at or below 200 percent of the federal poverty level (FPL), who are not covered by insurance including Medicare and not otherwise receiving benefits under another Medicaid program. P4HB covers Inter-Pregnancy Care (IPC) services, including primary care case management, for eligible women who have delivered a very low birth weight baby (VLBW) as of January 1, 2011. Women, actively receiving Medicaid, that have delivered a very low birth weight baby, may receive services in the Resource Mother component of P4HB (aid categories 182 and 183).

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

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

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

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

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

Effective October 2012, DFCS implemented the use of SVES.

AUTO ENROLLMENT

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

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

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

DUALLY ELIGIBLE

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

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

CHAPTER 400 APPLICATION AND ENROLLMENT PROCESS

401 Procedural Responsibilities of Qualified Hospitals

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

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

1. The QH shall conduct an interview with the applicant at which time the provider shall:
 - advise the applicant they may be eligible for Medicaid benefits as a PE beneficiary and for full Medicaid benefits for ongoing and retroactive Medicaid coverage;
 - inform the applicant about Planning for Healthy Babies (P4HB);
 - obtain adequate information from the applicant to complete the PE application form 632H, the declaration of citizenship/immigrant status form 216, and the HIPAA form;
 - determine if the applicant meets the PE Medicaid eligibility criteria;
 - assist an applicant with completing the single streamlined Medicaid application and obtain the applicant's signature. 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. Refer to section 502 for the complete list of acceptable citizenship/qualified immigrant/identity documents.

2. For any applicant determined presumptively eligible, the QH shall:
 - perform on-line entry of the application or forward a copy of the completed PE application form 632H the same day the PE application was completed; for data entry by the HP Member Contact Unit when a QH does not have internet access to GAMMIS;
 - provide the applicant with a temporary Medicaid certificate;

- fax a copy of the completed PE Medicaid application form 632H, the signed, completed single streamlined Medicaid application and the HIPAA form to DCH within five (5) calendar days upon completion of the PE Medicaid determination.
- inform the applicant of the PE time limit and the services covered;
- provide the applicant with a copy of the Medicaid Guide and fact sheet, “Quick Guide on Medicaid”, which explains the program and gives additional information;
- provide the applicant with the address and telephone number of the RSM/DFCS office where their application has been sent;
- inform the applicant about Planning for Healthy Babies (P4HB).

For any applicant determined not eligible for presumptive coverage, the QH shall:

- inform the applicant verbally and in writing via form 634H that they are not presumptively eligible;
- advise the applicant that if their circumstances change, they may have another determination of PE performed by a QH;
- inform the applicant that their application for Medicaid has been forwarded to the RSM/DFCS team for a formal determination of eligibility;
- forward signed, both 632H, a completed single streamlined Medicaid application and HIPAA form to DCH along with a copy of the denial 634H form;
- provide the applicant with the address and telephone number of their RSM/DFCS office;
- inform the applicant about Planning for Healthy Babies (P4HB).

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

- advise the member to contact the **DFCS Call Center**
(1-877-423-4746)

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

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

CHAPTER 500 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

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

501 Determination of Budget Group

Non-income requirements for PE include the declaration of Citizenship/Immigration Status; Georgia Resident; pregnancy statement; the appropriate age or being a Former Foster Care member when required by regulations.

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

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

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

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

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

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

PARENT- natural, adoptive or step.

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

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

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

SIBLING- natural, adoptive or step.

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

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

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

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

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

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

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

Three (3) exceptions for claimed tax dependents:

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

Note: If a taxpayer cannot reasonably establish that another individual is a tax dependent of a taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined.

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

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

Pregnant Woman– each expected child is included in the budget group for PE Medicaid; pregnancy, and number of expected children, is based on the applicant's statement only. Only Pregnancy Medicaid and Presumptive Eligible (PE) Pregnancy Medicaid allow multiple expected births to be included without medical verification of the number expected. All other Modified Adjusted Gross Income (MAGI) COAs need medical verification of

multiple births; otherwise count a pregnant woman in the budget group as two (her and one unborn child).

502 Citizenship/Immigration Status

§435.406 Citizenship and alienage

Policy

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

1. Lawfully admitted immigrants who arrived in the United States **before August 22, 1996**, if they are:
 - a) asylees, refugees, or have been granted parole in the U.S. for at least one year or have had their deportation withheld.
 - b) lawful permanent residents.
 - c) honorably discharged U.S. veterans or active duty military personnel, their spouses, or their unmarried dependent children.
2. Lawfully admitted immigrants who arrived in the United States **on or after August 22, 1996**, if they are:
 - a) asylees, refugees, or have been paroled in the U.S. for at least one year, or if their deportation is being withheld.
 - b) lawful permanent residents who have been credited forty (40) quarters of employment (10 years) under the U.S. Social Security system and have not received any federal means tested benefits during that time. (The employment test may be met also by the individual's spouse or parent.)
 - c) honorably discharged U.S. military veterans or active duty military personnel, their spouses, or unmarried dependent children.
 - d) individuals whose immigration status is in accordance with the Victims of Trafficking and Violence and Protection Act of 2000 (Public Law 106-386).

3. Lawfully admitted immigrants that entered the United States on or after August 22, 1996, and have been legal resident immigrant for five (5) years or more.

Procedures

QH must have all applicants complete a Declaration of Citizenship/Immigrant Status form 216 (Appendix F), as part of the PE application process. As with income, the applicant's statement of citizenship/immigrant status is acceptable. Verification of citizenship/immigrant status is not required; however, if the applicant does present proof of status at the PE interview, copies should be made and one retained in the PE file and one faxed to DCH at 404-463-2538, or scan the complete PE packet to pecorrections@dch.ga.gov.

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.

Acceptable identity and/or citizenship documents:

§435.407 Types of acceptable documentary evidence of citizenship

No Identity Required on these Citizenship Verifications:

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

Identity Required with these Citizenship Verifications:

- US Public Birth Record showing birth in one of the 50 states; District of Columbia; American Territories; or Guam
- US birth certificate or data match with a State Vital Statistic Agency
- Certification of Report of Birth (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the U.S.(FS-240)
- Certification of Birth Abroad (FS-545)
- United States Citizen Identification Card (I-197 or the prior version I-179)
- American Indian Card (I-872) with the classification "KIC" (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
- Collective Naturalization document/Northern Mariana Identification Card (I-873)
- Final Adoption Decree

- Evidence of civil service employment by the US government
- Official Military record
- Federal or State census record showing US citizenship indicating a US place of birth
- Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs
- Statement signed by the physician or midwife who was in attendance at the time of birth
- One of the following documents created at least 5 years before the application for Medicaid showing a US place of birth:
 - Extract of hospital record on hospital letterhead established at the time of person's birth
 - Life, health or other insurance record
 - An amended US public birth record
 - Medical clinic, doctor or hospital record indicating a US place of birth
 - Institutional admission papers from nursing home, skilled nursing care facility or other institution

Acceptable Verification of Identity:

- State Driver's license bearing the individual's picture **or** Georgia Identification Card
- Certificate of Indian Blood; US American/Alaska Native tribal document; or Native American Tribal Document
- US Military Card or draft record; Military dependent's ID card with photograph; US Coast Guard Merchant Mariner Card
- Identification card issued by federal, state or local government agencies or entities with photo or identifying information
- School Identification card with a photograph
- US passport issued with Limitations
- Data matches or documents from law enforcement or corrections agencies such as police or sheriff's departments, parole office, DJJ and Youth Detention Centers

Applicants should not be denied PE or the right to apply for the program because they cannot provide proof of citizenship/immigrant status. The application should be denied when they indicate that they are not a U.S. Citizen/Naturalized or not a qualified immigrant. An affirmative entry on the single streamlined application form meets the criteria for citizenship/immigrant status. If the declaration of citizenship/qualified immigrant is

completed, the individual(s) will be determined presumptively eligible provided that they met the other eligibility requirements; the family net taxable income is at or below the allowable the federal poverty level (FPL) income limit; they state they are pregnant; they are Georgia residents; they are a Former Foster Care beneficiary and/or they are the appropriate age per regulations.

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

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

If the applicant is verbally unable to confirm citizenship or that they are not a qualified immigrant, then the QH will deny the PE Medicaid application and fax the PE packet to DCH. QH will follow the procedures outlined in Chapter 703.

The applicant must be afforded the full opportunity to apply for PE Medicaid. This means all forms normally given during the course of the application process must be completed (forms DMA 632H, Declaration of citizenship/qualified immigrant status form 216, HIPAA and the single streamlined Medicaid application). The applicant cannot be given just the form 216 to complete and denied in the event they do not meet the citizenship/immigrant status requirements.

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

Copies of the form 216, in English and Spanish, are contained in Appendix F. Ample copies should be kept on hand. The single streamlined Medicaid application contains the citizenship/qualified immigrant declaration within the application, a separate form 216 is not required.

CHAPTER 600 FINANCIAL ELIGIBILITY REQUIREMENTS

601 Income

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

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

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

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

602 Non Taxable Income

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

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

603 Income Eligibility Limits

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.

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

Modified Adjusted Gross Income Limits for April 1, 2016

Budget Group	Parent/Caretaker with			Children 6-18		Children 1-5		Children 0-1		Pregnant Women		PCK		P4HB	
	Children	Under	Age 19												
	Limit	5%	Limit												
	FPL	Deduction	Plus 5%	133%	Plus 5%	149%	Plus 5%	205%	Plus 5%	220%	Plus 5%	247%	Plus 5%	200%	Plus 5%
1	310	50	360	1317	1367	1476	1526	2030	2080	2178	2228	2446	2496	1980	2030
2	457	67	524	1776	1843	1990	2057	2737	2804	2937	3004	3298	3365	2670	2737
3	551	84	635	2235	2319	2504	2588	3444	3528	3696	3780	4150	4234	3360	3444
4	653	102	755	2694	2796	3018	3120	4152	4254	4455	4557	5002	5104	4050	4152
5	752	119	871	3153	3272	3532	3651	4859	4978	5214	5333	5854	5973	4740	4859
6	826	136	962	3611	3747	4046	4182	5566	5702	5973	6109	6707	6843	5430	5566
7	903	154	1057	4072	4226	4561	4715	6276	6430	6735	6889	7561	7715	6122	6276
8	970	171	1141	4533	4704	5078	5249	6987	7158	7498	7669	8418	8589	6816	6987
9	1034	188	1222	4995	5183	5595	5783	7698	7886	8262	8450	9275	9463	7510	7698
10	1113	206	1319	5455	5661	6111	6317	8408	8414	9023	9229	10,130	10,336	8202	8408
11	1194	223	1417	5916	6139	6628	6851	9119	9342	9786	10,009	10,987	11,193	8896	9119
12	1244	240	1484	6378	6618	7145	7385	9830	10,070	10,550	10,790	11,844	12,084	9590	9830

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

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

604 Determination of Taxable Income

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

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

The three allowable deductions are:

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

Taxable income of the applicant's child, who is 18 years old or younger, is disregarded in full if they are not required to file income taxes.

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

605 Taxable Earned Income

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

When determining the income to be included from self-employment activities for the income comparison test, consider net income to be the total profit from the business. Net income is determined by deducting business expenses (those costs directly related to producing the goods or services that are allowable IRS deductions) from the gross income. The applicant's statement regarding gross income, receipts and costs of doing business, is accepted as establishing the amount of net income to be

included in the financial calculation. The applicant may state an amount equal to the net income amount for a stated period.

Rental income is the only self-employment income that can be budgeted as earned or unearned income, depending on the number of hours an applicant is engaged in property management.

If the applicant is actively involved in property management for at least 20 hours per week, count the net income (gross income less the cost of doing business) as earned income.

If the applicant is not actively involved in property management as least 20 hours per week, count the net income (gross income less the cost of doing business) as unearned income.

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

See Appendix I for a chart of Taxable Earned Income.

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

701 On-Line Procedures

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

701.1 Approvals

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

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

1. Data enter in the appropriate fields certain demographic information contained on the application. When processing over the Internet, the member's identification number will be issued by the system as part of the online process.
2. If all data are entered correctly, the system will allow production of a temporary Medicaid certificate. Print out two copies of this document. 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 they are approved for Medicaid. Instruct the applicant to present this document to her providers as proof of Medicaid eligibility.
3. Retain a copy of the temporary Medicaid certificate in the record, along with the PE application DMA 632H.

4. Within five (5) calendar days the PE application is completed, fax the PE packet to DCH at 404 463-2538. The RSM/DFCS team will review the member's eligibility for ongoing and retroactive Medicaid (if requested).

Note: Qualified hospitals are encouraged to exercise care when executing the online process. Errors on a Presumptive Eligibility record will cause denials or delays in the payment of claims.

If there are issues that occur when trying to add the approval to **GAMMIS**, first call HP at 1-800-766-4456 and have HP update the PE member manually while on the phone.

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

QH can call HP at 1-800-766-4456 to have these corrections completed or they can fax HP at 1-866-483-1045 using the PE Coversheet and attaching the PE application (632H).

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

The PE Coversheet can be found in Appendix F.

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

702 Manual Approvals

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

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

1. Complete a **form DMA 634H, Notice of Action**. The member should present this certificate to their medical care and pharmacy providers.
2. Send a copy of the PE Medicaid application for data entry to (**only if the QH does not have access to the Web portal**):

**Provider Contact Center
P.O. Box 105200
Tucker, GA 30085-5200**

3. Within five (5) calendar days the PE Medicaid application is completed, fax the PE packet to DCH at 404 463 2538.

PE Packets Include:

Form 632H

Form 634H (for manually updated approval only)

HIPPA

Single Streamlined Medicaid Application (94A)

Declaration of Citizenship/Immigration Status form 216 (if not included with single streamlined application form)

703 Denied Applications

If there is a qualifying member when the Hospital PE Medicaid application is denied, the data can be entered on the GAMMIS System.

Reasons for denial are: 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 Foster Care child 6) the applicant states she is not pregnant.

After the qualifying member has been entered the GAMMIS system, the qualifying member's Medicaid number is entered in the first field and it will pre-populate with the case information and then the correct denial reason can be selected from the drop down box. If after the completion of a PE application form DMA 632H and it is determined that there are no qualified applicants, the application is to be **denied** for PE, adhere to the following instructions:

1. Complete and give the applicant a copy of the **Notice of Action, DMA 634H**. 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 at 404-463-2538, or scan the complete PE packet to pecorrections@dch.ga.gov.

Note: Since single denied applicant cannot be entered, all QH offices, including those with Internet access, must follow these procedures for denials.

PE Packets Include:

Form 632H

Form 634H

HIPPA

Single Streamlined Medicaid Application

Declaration of Citizenship/Immigration Status form 216 (if not included with single streamlined application form)

APPENDIX A - QUESTIONS & ANSWERS

1. What forms are needed for a PE application?

- Application form DMA 632H
- Declaration of Citizenship/Qualified Immigrant form 216 (if the single streamlined application is not included)
- HIPAA

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

No. The single streamlined Medicaid application contains the Declaration of Citizenship/Qualified Immigrant language.

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

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

4. What reasons can PE Medicaid be denied for?

- Not being a Georgia Resident
- Not being a U.S. Citizen or qualified immigrant
- Not being at or below the appropriate FPL income limit
- Not being the appropriate age
- Not being a Former Foster Care child
- Not being pregnant per applicant's statement

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

- Inform the applicant they have been approved.
- Explain what PE Medicaid is.
- Explain what PE Medicaid covers.
- Explain what a temporary Medicaid certificate is and how they should use it.
- Explain the single streamlined Medicaid application form will be given to the RSM/DFCS team to make the Medicaid determination.
- Give the applicant the Quick Guide On Medicaid, and review the information.
- Inform the member of Planning for Healthy Babies (P4HB).

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

- Inform the applicant they have been denied, and why.
- Give them form DMA 634H Notice of Action or GAMMIS Denial Notice and review it with them.
- Explain the single streamlined Medicaid application form will be given to the RSM/DFCS team to make the Medicaid determination.
- Inform the applicant about Planning for Healthy Babies (P4HB).

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

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

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

QH should screen applications to confirm the applicant is not active on Medicaid. If the member is active on Medicaid, other than P4HB aid categories 180-181, or Q-Track aid categories 660-662, do not complete a PE application on line as PE is only temporary Medicaid.

Those members that are active for P4HB, aid categories 180-181, accept and complete the PE application and follow normal PE application procedures. Members that are active P4HB 182 or 183 have full Medicaid already.

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

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

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

QH should follow the procedures outlined in Chapter 700.

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

See step by step process in Appendix G.

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

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

Only taxable net earned and unearned income will be counted in the PE budget, and there are specific deductions allowed for certain income.

See Chapter 600 and Appendix I for Income information.

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

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

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

The right to apply does not mean the application must be completed the same day as they could walk in your office on a Friday at 4:58 P.M. The application should be processed timely the following business day.

Nor does the right to apply mean everyone is eligible for PE Medicaid.

13. How do I order forms?

Form DMA 632H can only be printed from the Web.

Single streamlined Medicaid application forms, Declaration of citizenship/qualified immigrant status forms, and HIPAA form should be obtained through RSM or DFCS.

Form 634H can be printed from the PE Manual.

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

Members should speak to their MCHB regarding P4HB.

Applicants should contact MAXIMUS for questions regarding P4HB:

1-877-744-2101

Fax 1-888-744-2102

www.planning4healthybabies.org

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

Qualified Hospitals should contact, pecorrections@dch.ga.gov regarding any P4HB regulations. Anything regarding claims/codes etc. Will need to be handled by the MCHB.

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

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

Adding the information onto the Web is an instant update which allows all providers to see the member's eligibility once it is entered on the Web.

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

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

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

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

This page can be found at: <http://www.uscis.gov/greencard>

17. When does time as a Permanent Resident begin?

Permanent Resident begins on the date they were granted permanent resident status. This date is on their Permanent Resident Card (formerly known as an Alien Registration Card or "Green Card").

Sample: This is what the new US green card looks like.
On May 11, 2010, USCIS announced a redesigned Green Card. The Green Card will now be colored green for easy recognition. The Green Card redesign is the latest advance in USCIS's ongoing efforts to deter immigration fraud. State-of-the-art technology incorporated into the new card prevents counterfeiting, obstructs tampering,

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

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

Student Visa Overview

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

1. F1 Visa: Academic Studies

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

2. J Visa: Academic Studies as an Exchange Visitor

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

3. M Visa: Non-Academic or Vocational Studies

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

Business Visa

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

Work Visa

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

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

Visitor VISA

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

APPENDIX C- CLASS OF ASSISTANCE

Aid Category

Medicaid

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

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10/01/15

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

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

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

Appendix E - Examples

Presumptive Eligibility Period

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

Budget Group Composition

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

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

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

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

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

Jane and her son are included in the budget group.

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

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

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

5. Lisa Mathews (22 years old) received foster care in New York until she aged out of the program at 18. She has moved to Georgia today with her three (3) year old child. She doesn't know if she will file a tax return this year or not. Who is included in the budget group?

For this household we have two different budget groups:

PE Former FosterCare 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.

Income

Michele Brown lives with her husband, her daughter (15), and three mutual children (8, 10, and 11). Michele is employed and earns \$2310.00, per month. She pays \$184 monthly for vision insurance (pre-tax). Her husband is employed as a machinist and earns \$2693.00, per month.

He pays \$300 monthly for MARTA (pre-tax), \$298 monthly for dental insurance and \$800 monthly alimony to his ex-wife. Michele receives \$1022.00, per month, child- support for her daughter. Determine financial eligibility.

\$ 2310.00	Mrs. Brown's earned income
<u>\$ -184.00</u>	Vision Insurance/Pre-tax
\$ 2126.00	Mrs. Brown's net taxable income
\$ 2693.00	Mr. Brown's earned income
<u>\$ -300.00</u>	MARTA/Pre-tax
\$ 2393.00	
<u>\$ -\$298.00</u>	Dental Insurance/Pre-tax
\$ 2095.00	
<u>\$ -800.00</u>	Alimony/1040 Deduction
\$ 1295.00	Mr. Brown's net taxable income
\$ 2126.00	Mrs. Brown's net taxable income
<u>\$ 1295.00</u>	Mr. Brown's net taxable income
\$ 3421.00	
<u>\$ -136.00</u>	5% FPL
\$ 3285.00 =	\$3,285 total net taxable income for the BG of 6

Parent/Caretaker with Child(ren) BG of 6 income Limit = \$826

Children Under 19 Years of Age BG of 6 income limit = \$3611

PE eligible for Children Under 19 years of Age Medicaid

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

\$ 421.00	Mrs. Jones' taxable earned income
<u>\$ 960.00</u>	Mr. Jones' taxable earned income
\$ 1381.00	Total taxable net income
<u>\$ 102.00</u>	5% FPL (BG of 4)
\$ 1280.00	= \$1280 total net taxable income

Parent/Caretaker with Child(ren) BG of 4 income Limit = \$653

Children Under 19 Years of Age (15) BG of 4 income limit = \$2694

Children Under 19 Years of Age (3) BG of 4 income limit = \$3018

PE eligible for Children Under 19 years of Age Medicaid

Revised
7/1/16

Peter Thompson (42) lives with his children, Katie (6), Peter Jr. (11), and Pamela (15). Mr. Thompson is employed and earns \$350/weekly. He pays \$50/month for dental insurance and \$20/month for vision insurance. The children only receive \$450/month for RSDI. Mr. Thompson does file taxes and claims all three kids as tax dependents. Determine financial eligibility.

\$350 x 4.3333 = \$1516.65	Mr. Thompson's earned income
<u>\$ -50.00</u>	Dental Insurance/Pre-tax
\$1466.65	
<u>\$ -20.00</u>	Vision Insurance/Pre-tax
\$1446.65	Mr. Thompson's net taxable income
<u>\$-102.00</u>	5% FPL (BG of 4)
\$1344.65	Total net taxable income

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

Parent/Caretaker with Child(ren) BG of 4 income limit = \$653

Children under 19 Years of Age BG of 4 income limit = \$2694

PE eligible for Children under 19 Years of age Medicaid

Conversion Factor

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

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

Pre-tax Deductions:

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

22222		a Employee's social security number		OMB No. 1545-0008		
b Employer identification number (EIN)			1 Wages, tips, other compensation		2 Federal income tax withheld	
c Employer's name, address, and ZIP code			3 Social security wages		4 Social security tax withheld	
			5 Medicare wages and tips		6 Medicare tax withheld	
			7 Social security tips		8 Allocated tips	
d Control number			9		10 Dependent care benefits	
e Employee's first name and initial		Last name		Suff.		
f Employee's address and ZIP code			11 Nonqualified plans		12a	
			13 Retiree annuities		12b	
			14 Other		12c	
					12d	
15 State Employer's state ID number		16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name
<p>Form W-2 Wage and Tax Statement 2016 Department of the Treasury—Internal Revenue Service</p> <p>Copy 1—For State, City, or Local Tax Department</p>						

1040 Deductions:

Are located on the IRS Tax Return form 1040:

Adjusted Gross Income	23	Educator expenses	23			
	24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24			
	25	Health savings account deduction. Attach Form 8889	25			
	26	Moving expenses. Attach Form 3903	26			
	27	Deductible part of self-employment tax. Attach Schedule SE	27			
	28	Self-employed SEP, SIMPLE, and qualified plans	28			
	29	Self-employed health insurance deduction	29			
	30	Penalty on early withdrawal of savings	30			
	31a	Alimony paid b Recipient's SSN ▶	31a			
	32	IRA deduction	32			
	33	Student loan interest deduction	33			
	34	Tuition and fees. Attach Form 8917	34			
	35	Domestic production activities deduction. Attach Form 8903	35			
	36	Add lines 23 through 35	36			
37	Subtract line 36 from line 22. This is your adjusted gross income ▶	37				
<p>For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 11320B Form 1040 (2015)</p>						

INSTRUCTIONS ON FORMS

PRESUMPTIVE ELIGIBILITY Medicaid APPLICATION: REVISED 08/2015

The Presumptive Eligibility Medicaid Application is used to record information needed to determine eligibility. If approved, beneficiaries are to be given a temporary Medicaid certificate as proof of eligibility.

The form is divided into three parts. The top third of the form reflects demographic information of the applicant and the month for which the Medicaid is valid. The middle third of the form reflects budget group information including income data. The bottom third of the form consists of the sworn statement of the applicant; along with the qualified hospital provider information.

1. The form should be routed according to the directions given in the instructions for processing applications located within this manual. If the applicant is not eligible, give them form 634H only. A copy of this form should be kept in the QH's patient file and another copy, regardless of approved or denied, fax the PE packet to DCH at 404-463-2538, or scan the complete PE packet to pecorrections@dch.ga.gov as part of the PE Packet.

Completion of Individual Items:

- | | |
|---|--|
| 1) <u>Effective for Services Beginning:</u> | Enter month as a two-digit number beginning with 01 for January. Always show the first day of the month (01). Enter the last two digits of the year. |
| 2) <u>Medicaid Identification Number:</u> | List her twelve (12) digit number that begins with 111 or 222. |
| 3) <u>Valid for Listed Month Only:</u> | Enter the months and year in which the Presumptive Eligibility determination was made. Month of application to the end of the next month. |
| 4) <u>Applicant's Name:</u> | Enter name of applicant. |
| 5) <u>Applicant's Address:</u> | Enter mailing address where card is to be sent. |
| 6) <u>City, State, Zip Code:</u> | Self-explanatory. |
| 7) <u>County of Residence:</u> | Enter applicant's county of residence even if different from provider's county of residence. |
| 8) <u>Telephone and SS Number:</u> | Self-explanatory. |
| 9) <u>Patient's Record Number:</u> | For provider's use in identifying patient on their system. |

- 10) Date of Interview: Enter month, day and year applicant provided information for form.
- 11) Family Member(s): Enter the applicant's name on the first line. Enter the names of the remaining budget group members on the remaining lines.
- 12) Date of Birth: Enter the birthdates of all budget group members.
- 13) Race, Sex and Relationship to Applicant: Enter for all members.
- 14) Monthly Gross Taxable Income: Enter the type of taxable income:
C = Commissions
OE = Other Taxable Earnings
P = Pensions
SE = Self-employment
OU = Other Taxable Unearned Income
W = Taxable Wages or Salaries
- Enter amount received and how often:
B = Biweekly
H = Hourly
M = Monthly
Q = Quarterly
S = Semi-Monthly
W = Weekly
Y = Yearly
- Convert all income to a monthly amount.
- 15) Monthly Deductions: Enter monthly Pre-Tax deductions; monthly 1040 deductions.
- 16) Monthly Net Income: Enter taxable net income for each budget group member by subtracting allowable deductions from monthly gross taxable income.
- 17) Total Gross Taxable Income: Enter monthly total gross taxable income for the budget group.
- 18) Number in Family: Enter number of persons included in the budget group.
- 19) Poverty Level Income: Enter the amount of the income standard for the budget group size.

- 20) Subtotal Net Income: Enter the monthly total taxable net income for the budget group.
- 21) 5% FPL Exclusion: Enter the 5% FPL of the budget group.
- 22) Total Family Taxable Net Income: Enter the amount remaining after the 5% FPL amount is subtracted from the total taxable net income. Compare this amount to the poverty standard in item 19. If income is less, check the eligible box. If income is more, check the ineligible box.
- 23) Sworn Statement of Beneficiary: Have the applicant sign and date the application after they have read or had read to them the declaration of understanding. The person preparing the application should sign and date the form as well.
- 24) Qualified Hospital : The qualified hospital enters their complete provider information including name of QH, provider ID, direct phone number of person completing the application

Qualified Hospitals are to use this PE form 632H for all PE Parent/Caretaker with Child(ren); or PE Children Under 19 Years of Age; or PE Pregnant Woman; or PE Former FosterCare. For PE Women's Health Medicaid please refer to the PE WHM Manual on line and use the PE WHM application form 632W.

PE WHM has different income types to consider; different regulations for determining budget groups; different allowable deductions.

PE Former FosterCare child does not have an income limit and the applicant is the only BG member.

EFFECTIVE FOR SERVICES

HP PROVIDER CONTACT CENTER
PHONE: 1-800-766-4456 FAX: 1-866-483-1044

BEGINNING _____
MONTH DAY YEAR

MEDICAID IDENTIFICATION NUMBER _____

QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY DETERMINATION

APPLICANT'S NAME: _____ MAIDEN NAME: _____ DO YOU HAVE HEALTH INSURANCE? YES NO

APPLICANT'S ADDRESS: _____ TELEPHONE NUMBER: _____ FORMER FOSTER CARE CHILD: YES NO

APARTMENT/LOT NUMBER: _____ SOCIAL SECURITY NUMBER: _____
OPTIONAL WHAT AGE DID YOU LEAVE FOSTER CARE _____
IN WHAT STATE DID YOU RECEIVE FOSTER CARE? _____

CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY OF RESIDENCE: _____

	TAX FILER HOUSEHOLD				DATE OF BIRTH MM/DD/YYYY	+ RACE	GENDER	RELATION TO APPLICANT	MONTHLY GROSS TAXABLE INCOME				MONTHLY DEDUCTIONS		MONTHLY NET TAXABLE INCOME
	YES	NO	YES	NO					TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	PRE-TAX DEDUCTION	1040 DEDUCTION	
01								SELF							
02	UNBORN CHILD	N/A	PREGNANT WITH	FETUS (US)	EDD			APPLICANT'S STATEMENT/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 RIGHT FROM THE START MEDICAID (RSM) PROJECT OR COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) 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 LAWFULLY PRESENT IMMIGRANT 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, PRE-TAX DEDUCTIONS, 1040 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 RSM OR DFCS OFFICE MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY, OR NO LATER THAN THE LAST DAY OF THE FOLLOWING MONTH.

I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS THROUGH WWW.COMPASS.GA.GOV OR CALL 1-877-423-4746 (TDD/TTY 1-800-255-0135); FAX 1-888-740-9355.

DATE OF APPLICATION _____ APPLICANT'S SIGNATURE _____

*By providing Race information, you will assist us in administering our programs in a non-discriminatory manner. You are not required to give us this information and it will not affect your eligibility or benefit level.

DMA 632H (08/13/2015)

TOTAL GROSS TAXABLE INCOME =
NUMBER IN BUDGET GROUP =
POVERTY INCOME LEVEL =

SUBTOTAL NET INCOME =
5 % FPL DEDUCTION =
TOTAL NET INCOME =

APPLICANT IS ELIGIBLE OR INELIGIBLE FOR THE FOLLOWING PRESUMPTIVE ELIGIBILITY CLASS OF ASSISTANCE:

- PARENT/CARETAKER WITH CHILD(REN) PREGNANT WOMAN
- CHILD(REN UNDER 19) FORMER FOSTER CARE (Up to age 26)

I HAVE OBTAINED A HEALTHCARE COVERAGE APPLICATION (94A) FROM THE APPLICANT AND HAVE FAXED IT TO DCH AT 404 469-2538. YES (Included in PE Packet) NO

APPLICANT'S INITIALS _____

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

DIRECT PHONE NUMBER _____ SIGNATURE OF QUALIFIED HOSPITAL PERSONNEL _____

QUALIFIED HOSPITAL NAME AND ADDRESS _____ QH PROVIDER ID _____

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

SPECIAL NOTE TO BENEFICIARY:

If you have not heard from RSM/DFCS about your application for Medicaid in thirty (30) days, please contact them.

INSTRUCTIONS TO BENEFICIARY:

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

INSTRUCTIONS TO PROVIDER:

Medical assistance services are to be provided in accordance with the Department of Community Health Plan up to and including the last day of the month specified on the temporary Medicaid certificate. Certification must be requested each time a service is requested. Always check for other proof of identity. Enter the complete member number as shown for the person receiving the service on the medical assistance claim form. Contact GAMMIS on questions regarding member eligibility.

NOTICE TO OUT OF STATE PROVIDER:

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

NOTICE TO BENEFICIARY:

Your eligibility under this special program stops when the county Division of Family and Children services makes the decision for your continuing eligibility. When you applied for this special coverage, you also applied for Medicaid. When a decision is made on your Medicaid (continuing) eligibility, you will receive a written explanation regarding your continuing eligibility for Medicaid. If you disagree with the decision on your continuing eligibility, you may request a hearing on that decision. Because presumptive eligibility is a temporary special coverage, you are not entitled to a hearing when your presumptive coverage stops.

SINGLE STREAMLINED MEDICAID APPLICATION

This form is used to apply for ongoing and retroactive Medicaid benefits. The applicant must complete this document as part of the Presumptive Eligibility application process. It should be included in the Presumptive Eligibility package; fax the PE packet to DCH at 404-463-2538, or scan the complete PE packet to pecorrections@dch.ga.gov. These documents are available in English and Spanish.

Application for Health Coverage & Help Paying Costs

Form Approved
OMB No. 0938-1191

THINGS TO KNOW



Use this application to see what coverage choices you qualify for

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



Who can use this application?

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



Apply faster online

Apply faster online at Compass.ga.gov.



What you may need to apply

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



Why do we ask for this information?

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



What happens next?

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



Get help with this application

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



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

ATTACHMENT A

Health Coverage from Jobs

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

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

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

EMPLOYEE Information

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

EMPLOYER Information

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

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? <input type="checkbox"/> Yes (Continue) 13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy) List the names of anyone else who is eligible for coverage from this job. Name: _____ Name: _____ Name: _____ <input type="checkbox"/> No (Stop here and go to Step 5 in the application)
--

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

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

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

NEED HELP WITH YOUR APPLICATION? Visit Compass.ga.gov or call us at 1-877-423-4746. Para obtener una copia de este formulario en Español, llame 1-877-423-4746. If you need help in a language other than English, call 1-877-423-4746 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-255-0135.
Form 94a Appendix A (1/14)

EMPLOYER COVERAGE TOOL

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

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



EMPLOYEE Information

The employee needs to fill out this section.

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



EMPLOYER Information

Ask the employer for this information.

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

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

Yes (Continue)

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

No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

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

Yes. Which people? Spouse Dependent(s)

No

(Go to question 14)

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

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

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

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

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

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

Employer won't offer health coverage

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

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

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

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



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

Form 94a Appendix A (1/14)



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

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

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

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

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

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



NEED HELP WITH YOUR APPLICATION? Visit Compass.ga.gov or call us at 1-877-423-4746. Para obtener una copia de este formulario en Español, llame 1-877-423-4746. If you need help in a language other than English, call 1-877-423-4746 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-255-0135.
Form 94a Appendix B (1/14)

Assistance with Completing this Application

You can choose an authorized representative.

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

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

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

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

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

 **NEED HELP WITH YOUR APPLICATION?** Visit Compass.ga.gov or call us at 1-877-423-4746. Para obtener una copia de este formulario en Español, llame 1-877-423-4746. If you need help in a language other than English, call 1-877-423-4746 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-255-0135.
Form 94a Appendix C (1/14)



Solicitud para Cobertura de Salud y Ayuda Pagando el Costo

COSAS PARA SABER



Use esta solicitud para ver cuáles opciones de cobertura usted califica

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



¿Quién puede usar esta Solicitud?

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



Solicite más rápido en línea

Solicite más rápido en línea Compass.ga.gov.



Qué necesita para solicitar

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



¿Por qué pedimos esta información?

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



¿Qué pasa después?

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



Consiga ayuda para hacer esta solicitud

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



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-8135.

Form 946 (Rev. 1/14) - 506604

Paso 1: Cuéntenos sobre usted.

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

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

Paso 2: Cuéntenos sobre su familia.

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

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

Incluya:

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

NO tiene que incluir:

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

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

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



¿Necesita ayuda con su solicitud? Visite dhs.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y díjale al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-888-295-8335.

Form 94a (Rev. 1/14) - Español

Página 1 de 8

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

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

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

3. Fecha de nacimiento (MM/DD/AAAA): _____	4. Sexo <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino
--	--

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

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

6. **¿Planes presentar una declaración de impuestos federal el PRÓXIMO AÑO?**
(Aunque no presente una declaración de impuestos, usted puede solicitar para seguro de salud.)

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

a. ¿Va a declarar conjunto con su cónyuge? Sí No
Si sí, nombre del cónyuge: _____

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

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

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

8. **¿Necesita cobertura de salud?**
(Aunque tenga seguro, puede haber un programa con mejor cobertura o un costo más bajo.)

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

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

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

11. **Si usted es un ciudadano(a) o nacional de los Estados Unidos,** ¿es un inmigrante calificado?

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

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

c. ¿Ha vivido usted en los Estados Unidos desde el 1995? Sí No d. ¿Es usted o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? Sí No

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

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

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

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

Mexicano Mexicanoamericano Chicano Puertorriqueño Cubano Otro _____

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

<input type="checkbox"/> Blanco	<input type="checkbox"/> Indígena estadounidense o de Alaska	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamita	<input type="checkbox"/> De Guam o chamorros
<input type="checkbox"/> Negro o afroamericano	<input type="checkbox"/> De la India	<input type="checkbox"/> Japonés	<input type="checkbox"/> Otro asiático	<input type="checkbox"/> De Samoa
	<input type="checkbox"/> Chino	<input type="checkbox"/> Coreano	<input type="checkbox"/> Indígena de Hawái	<input type="checkbox"/> De otra isla del Pacífico
			<input type="checkbox"/> Otro	

? **¿Necesita ayuda con su solicitud?** Visite compra.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-888-255-0135.

Form 94a (Rev. 1/14) - Español Página 2 de 8

PASO 3

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

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

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

PASO 4

La cobertura de salud de su familia

Conteste estas preguntas para cualquiera que necesite cobertura de salud.

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

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

<input type="checkbox"/> Medicaid _____	M	<input type="checkbox"/> Seguro del empleador _____
<input type="checkbox"/> Medicaid for Kids ®	E	<input type="checkbox"/> Nombre del seguro de salud: _____ Número de póliza: _____
<input type="checkbox"/> Medicare _____	M	¿Es esta una cobertura de COBRA? <input type="checkbox"/> Sí <input type="checkbox"/> No
<input type="checkbox"/> Medicare _____	T	¿Es éste un plan de salud de jubilación? <input type="checkbox"/> Sí <input type="checkbox"/> No
<input type="checkbox"/> MICARE (No marque si tiene cuidado directo o Line of Duty)	T	<input type="checkbox"/> Otro
<input type="checkbox"/> _____	Pr	Nombre del seguro de salud: _____
		Número de póliza: _____
		¿Es éste un plan con beneficios limitados (como una póliza escolar de accidente)? <input type="checkbox"/> Sí <input type="checkbox"/> No

2. ¿A alguien inscrito en esta solicitud le ha otorgado esa cobertura de salud de su trabajo? Marque Sí aunque la cobertura sea del trabajo de otra persona como un padre (madre) o cónyuge.

- Sí**. Si **Sí**, necesitará completar e incluir el anejo A.
 No. Si **No**, continúe al paso 5.

PRÁCTICA DE INVESTIGACIÓN

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



¿Necesita ayuda con su solicitud? Visite www.dhs.gov llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-888-295-8135.

Form 946 (Rev. 1/14) - Español

Página 6 de 8

PASO 5

Lea y firme esta solicitud.

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

(espacio de la persona)

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

Renovación de cobertura en los próximos años

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

Sí, renueve mi elegibilidad automáticamente por los próximos

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

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

Si a alguien en esta solicitud es elegible para Medicaid

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

Mi derecho a apelar

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

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

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



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-888-255-8135.

Form 946 (Rev. 1/14) - Spanish

Página 7 de 8

PASO 6

Envíe la solicitud completa.

Envíe su solicitud firmada a la dirección abajo:

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

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



¿Necesita ayuda con su solicitud? Visite www.sos.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y díjale al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-888-255-8135.

Form 94a (Rev. 1/14) - Español

Página 5 de 8

ANEXO A

Cobertura de salud de los trabajos

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

Cuéntenos sobre el trabajo que ofrece la cobertura.

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

Información sobre el EMPLEADO

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

Información sobre el EMPLEADOR

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

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

Sí (Continúe)

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

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

Nombre: _____ Nombre: _____ Nombre: _____

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

Cuéntenos sobre el plan de salud ofrecido por este empleador.

14. ¿El empleador ofrece un plan de salud que satisface el estándar del valor mínimo* <input type="checkbox"/> Sí <input type="checkbox"/> No
15. Para el plan de salud más barato que satisfaga el estándar del valor mínimo* ofrecido sólo al empleado (no incluya planes familiares): Si el empleador tiene programas de bienestar, proporcione la prima que el empleado tendría que pagar si él/ ella recibiera el máximo descuento por cualesquiera programas para dejar de fumar, y si no recibiera ningún otro descuento basado en los programas de bienestar. a. ¿Cuánto, en primas, tendría que pagar el empleado por este plan? \$ _____ b. ¿Con qué frecuencia? <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces al mes <input type="checkbox"/> Mensual <input type="checkbox"/> Trimestral <input type="checkbox"/> Anual
16. ¿Qué cambio hará el empleador para el nuevo año del plan (si se sabe)? <input type="checkbox"/> El empleador no ofrecerá cobertura de salud <input type="checkbox"/> El empleador comenzará a ofrecer una cobertura de salud a los empleados o a cambiar las primas para el plan más barato disponible, solamente para el empleado, que satisfaga el estándar del valor mínimo.* (La prima debe reflejar el descuento por los programas de bienestar. Vea la pregunta 15.) a. ¿Cuánto, en primas, tendrá que pagar el empleado por ese plan? \$ _____ b. ¿Con qué frecuencia? <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces al mes <input type="checkbox"/> Mensual <input type="checkbox"/> Trimestral <input type="checkbox"/> Anual Fecha del cambio (mm/dd/aaaa): _____

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

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

Form 94a Appendix A (1/14)



EMPLEADOR

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

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



Información sobre el EMPLEADO

El empleado tiene que llenar esta sección.

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



Información sobre el EMPLEADOR

Pídale al empleador esta información.

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

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

Sí (Continúe)

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

No (PARE y devuelva este formulario al empleado)

Cuéntenos sobre el plan de salud ofrecido por este empleador.

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

Sí. ¿A quién? Cónyuge Dependiente(s)

No

(Vaya a la pregunta 14)

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

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

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

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

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

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

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

El empleador no ofrecerá cobertura de salud

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

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

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

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

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

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

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

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

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

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

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

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

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



Ayuda para completar esta solicitud

Usted puede escoger a un representante autorizado.

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

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

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

Únicamente para consejeros, navegadores, representantes e intermediarios certificados.

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

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

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

Form 94a Appendix C (1/14)

NOTICE OF ACTION Form DMA 634H:

634H Approval

This form is used to provide notice to the applicant when a PE determination is approved and the temporary Medicaid certificate was not printed. It is to be given to the beneficiary at the time of her PE approval. A copy of this form should be included in the PE packet faxed to DCH at 404-463-2538, or scan the complete PE packet to pecorrections@dch.ga.gov.

634 Denial

This form is used to provide notice to the applicant when a PE determination is denied. It is to be given to the applicant at the time they are determined not eligible. A copy of this form should be included in the PE packet faxed to DCH at 404-463-2538, or scan the complete PE packet to pecorrections@dch.ga.gov.

COMPLETION OF INDIVIDUAL ITEMS:

Complete the top part of the form showing identifying information:

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

- Net taxable income exceeds the income standard
- Not the correct age for the Medicaid
- Does not meet the citizenship/qualified immigrant status requirements
- Not a GA resident
- Not a Former Foster Care child
- Not pregnant per the applicant's statement
- Unable to determine, applicant refuses to verbally give tax status information.

Enter whichever reason is correct.

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

The person completing the Presumptive Eligibility determination will sign the form



NOTICE OF ACTION

Presumptive Eligibility Medicaid

Name _____ Date _____
Address _____
City _____ State GA Zip Code _____

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

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

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

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

Signature of Qualified Provider _____ Qualified Provider Address _____

Title _____ Phone Number _____ Qualified Provider ID _____

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



NOTICE OF ACTION

Presumptive Eligibility Medicaid

Name _____ Date _____
Address _____
City _____ State GA Zip Code _____

B. PRESUMPTIVE ELIGIBILITY DENIED:

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

The reason for denial is: Not a Former Foster Care Child

When you applied for PE Medicaid, you may also have applied for Healthcare coverage. Your Healthcare coverage application has been sent to the Division of Family and Children Services (DFCS) office or the Right from the Start Medicaid (RSM) Project for a final determination of eligibility.

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 _____ Qualified Provider Address _____

Title _____ Phone Number _____ Qualified Provider ID _____

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

Declaration of Citizenship/Immigration Status:

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

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

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

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

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

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

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

CHILDREN SEEKING BENEFITS

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

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

SIGNATURE (PARENT GUARDIAN) (DATE)

ADULT(S) SEEKING BENEFITS

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

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

SIGNATURE (DATE)

SIGNATURE (DATE)

DECLARACIÓN DE LA CIUDADANÍA/ESTATUS DE EXTRANJERO

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

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

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

NIÑOS QUE BUSCAN BENEFICIOS

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

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

 FIRMA (PADRE/MADRE/GUARDIAN)

 (FECHA)

ADULTO(S) QUE BUSCA(N) BENEFICIOS

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

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

 FIRMA

 (FECHA)

 FIRMA

 (FECHA)

Notice of Privacy Practices form 5460:

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

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

The privacy regulation has three major purposes:

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

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

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

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

_____ :
ADD DFCS INFORMATION HERE

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

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

APPLICANT'S SIGNATURE HERE

APPLICANT'S MAILING ADDRESS HERE

APPLICANT'S PRINTED NAME

(Please print name)

Date
City,

State, Zip

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

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

HIPAA Notice of Privacy Practices Georgia Department of Human Services

Effective Date: August 15, 2013

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

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

Georgia Department of Human Services

HIPAA Privacy Officer

HIPAA1@dhr.state.ga.us

(404) 657-9761 phone

(404) 657-1123 fax

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

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

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

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

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

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

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

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

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

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

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

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

SPECIAL SITUATIONS:

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

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

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

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

Military and Veterans. If you are a member of the armed forces, DHS may release Health Information as required by military command authorities. DHS also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. DHS may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. DHS may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if it is believed a patient has been the victim of abuse, neglect or domestic violence. DHS will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. DHS may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. DHS may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, DHS may disclose Health Information in response to a court or administrative order. DHS also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. DHS may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. DHS may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. DHS also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. DHS may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. DHS may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE DHS TO PROVIDE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

Disaster Relief. DHS may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. DHS will provide you with an opportunity to agree or object to such a disclosure whenever it is practical to do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to DHS will be made only with your written authorization. If you do provide DHS an authorization, you may revoke it at any time by submitting a written revocation to the above-referenced Privacy Officer. Upon receipt, DHS will no longer disclose Protected Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information DHS has about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the above referenced HIPAA Privacy Officer. DHS has up to 30 days to make your Protected Health Information available to you

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

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

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

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

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

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

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

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

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

CHANGES TO THIS NOTICE:

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

COMPLAINTS:

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

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

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

Signature

Date

Print Name

**Aviso sobre prácticas de privacidad de HIPAA
Departamento de Servicios Humanos de Georgia**

Fecha de entrada en vigencia: 15 de agosto de 2013

**ESTE AVISO DESCRIBE CÓMO SE PUEDE UTILIZAR Y DIVULGAR LA INFORMACIÓN MÉDICA
SOBRE USTED Y COMO USTED PUEDE ACCEDER A ESTA INFORMACIÓN.
LEA ESTE AVISO CON ATENCIÓN.**

Si tiene dudas con respecto a este aviso, comuníquese con nosotros:

Departamento de Servicios Humanos de Georgia
Funcionario de privacidad de HIPAA
HIPAA1@dhr.state.ga.us
Phone: (404) 657-9761
Fax: (404) 657-1123

El Departamento de Servicios Humanos (DHS) es el organismo del poder ejecutivo del Gobierno de Georgia a cargo de la administración de muchos programas federales responsables del almacenamiento, el uso y el mantenimiento de información médica y otros tipos de información confidencial. Las leyes federales y estatales establecen requisitos estrictos para estos programas en cuanto al uso y la divulgación de información confidencial y protegida. El DHS debe cumplir con esas leyes, tal como se indica a lo largo de este Aviso.

OBLIGACIONES DEL DEPARTAMENTO DE SERVICIOS HUMANOS:

La ley exige al DHS lo siguiente:

- Mantener la privacidad de la información médica protegida.
- Entregarle este aviso de nuestras obligaciones legales y prácticas de privacidad con respecto a la información médica sobre usted.
- Cumplir con los términos del aviso que esté en vigencia actualmente.

DE QUÉ MANERA EL DHS DEBE USAR Y DIVULGAR LA INFORMACIÓN MÉDICA:

A continuación, se describen las formas en las que el DHS puede usar y divulgar información médica que lo identifica a usted ("Información Médica"). Salvo en el caso de los fines que se describen a continuación, el DHS usará y divulgará su Información Médica únicamente con su autorización por escrito. Puede comunicándose con el funcionario de privacidad de HIPAA (información de contacto mencionada anteriormente) para anular esa autorización en cualquier momento.

Para el tratamiento. El DHS puede usar y divulgar la Información Médica necesaria para realizar su tratamiento y para brindarle los servicios médicos relacionados con su tratamiento. Por ejemplo, el DHS puede divulgar Información Médica a médicos, enfermeros, técnicos u otros empleados que participen en su atención médica y necesiten la información para ofrecerle la atención médica.

Para el pago. El DHS puede usar y divulgar Información Médica para que el DHS y otros puedan facturar y recibir los pagos relacionados con su atención, una compañía de seguros o un tercero por el tratamiento y los servicios que recibió. Por ejemplo, el DHS puede brindar información sobre su plan de salud para que se pueda pagar el tratamiento.

Para operaciones sanitarias. El DHS puede usar y divulgar Información Médica con fines de operaciones sanitarias. Estos usos y divulgaciones son necesarias para asegurar que se reciba una atención de calidad y para operar, dirigir y administrar las funciones del organismo. Por ejemplo, el DHS puede usar y divulgar información para asegurar que la atención médica que usted reciba sea de la mejor calidad. El DHS también puede compartir información con otras entidades relacionadas con usted (por ejemplo, su plan de salud) para que realicen sus actividades de operaciones sanitarias.

Recordatorios de citas, alternativas de tratamiento y beneficios y servicios relacionados con la salud. El DHS puede usar y divulgar Información Médica para comunicarse con usted a fin de recordarle una cita con un médico. El DHS también puede usar y divulgar Información Médica para informarle sobre alternativas de tratamiento o beneficios y servicios relacionados con la salud que le podrían interesar.

Personas que participan en su atención o el pago de su atención. Cuando sea pertinente, el DHS puede compartir Información Médica con una persona que participe en su atención médica o el pago de su atención, como un familiar o amigo cercano. El DHS también puede notificar a su familia sobre su ubicación o estado general, o divulgar esa información a una entidad que asista en actividades de socorro.

Investigación. En algunas circunstancias, el DHS puede usar y divulgar Información Médica para investigación. Por ejemplo, puede haber un proyecto de investigación para comparar la salud de los pacientes que realizaron un tratamiento con los hicieron otro tratamiento para la misma enfermedad. Antes de que el DHS use o divulgue Información Médica para investigaciones, el proyecto pasará por un proceso de autorización especial. Incluso sin una autorización especial, el DHS puede permitir a investigadores que miren los registros a fin de identificar a los pacientes que se podrían incluir en su proyecto de investigación o con fines similares, siempre y cuando no eliminen ni se lleven una copia de ninguna Información Médica.

SITUACIONES ESPECIALES:

Según lo exige la ley. El DHS divulgará Información Médica cuando lo exijan las leyes internacionales, federales, estatales o locales.

Para evitar una amenaza seria a la salud o la seguridad. El DHS puede usar y divulgar Información Médica cuando sea necesario para evitar una amenaza seria a su salud o seguridad, o a la salud o seguridad del público o de otra persona. La divulgación, sin embargo, se hará únicamente a las personas que puedan ayudar a evitar la amenaza.

Socios comerciales. El DHS también puede divulgar Información Médica a nuestros socios comerciales que realicen funciones en nuestro nombre o que nos brinden servicios si la información es necesaria para esas funciones o servicios. Por ejemplo, el DHS puede utilizar los servicios de otra entidad para realizar la facturación. Todos los socios comerciales del DHS están obligados a proteger la privacidad de su información y no se les permite usar ni divulgar ninguna información que no esté especificada en nuestro contrato.

Donación de órganos y tejidos. Si usted es donante de órganos, el DHS puede usar o entregar Información Médica a organizaciones que se dedican a la obtención de órganos u otras entidades que participen en la obtención, el abastecimiento de bancos y el transporte de órganos, ojos o tejidos para facilitar la donación y el trasplante de órganos, ojos o tejidos.

Militares y veteranos. Si es miembro de las fuerzas armadas, el DHS puede divulgar la Información Médica que soliciten las autoridades militares. El DHS también puede divulgar Información Médica a la autoridad militar extranjera correspondiente si usted es miembro de fuerzas extranjeras.

Indemnización por accidentes laborales. El DHS puede divulgar Información Médica a programas de indemnización por accidentes laborales o programas similares. Estos programas proveen los beneficios por accidentes o enfermedades laborales.

Riesgos para la salud pública. El DHS puede divulgar Información Médica para actividades de salud pública. Estas actividades suelen incluir la divulgación a fin de prevenir o controlar una enfermedad, lesión o discapacidad, informar nacimientos y defunciones, denunciar abuso o abandono infantil, informar reacciones a medicamentos o problemas con productos, notificar a las personas sobre la retirada de un producto que pueden estar usando, notificar a una persona que se pudo haber expuesto a una enfermedad o puede estar en riesgo de contraer o contagiar una enfermedad, e informar a las autoridades gubernamentales correspondientes si se cree que un paciente fue víctima de abuso, abandono o violencia doméstica. El DHS únicamente hará esta divulgación si usted está de acuerdo o si lo exige o lo autoriza la ley.

Actividades de supervisión de la salud. El DHS puede divulgar Información Médica a un organismo de supervisión de la salud para actividades autorizadas por la ley. Estas actividades de supervisión de la salud incluyen, por ejemplo, auditorías,

investigaciones, inspecciones y certificaciones. Estas actividades son necesarias para que el gobierno supervise el sistema sanitario, los programas gubernamentales y el cumplimiento de las leyes de derechos civiles.

Fines de notificación de una violación a la confidencialidad de la información. El DHS puede usar o divulgar su Información Médica protegida a fin de emitir avisos exigidos por ley en caso de que se haya accedido a su Información Médica o se la haya divulgado sin la autorización correspondiente.

Juicios y litigios. Si está involucrado en un juicio o litigio, el DHS puede divulgar Información Médica si nos lo exige una orden administrativa o judicial. El DHS también puede divulgar Información Médica en caso de citación judicial, pedido de presentación de pruebas y otro proceso legal de otra persona que esté involucrada en el litigio, pero únicamente si se ha hecho todo lo posible para informarle a usted sobre el pedido o para obtener una orden que proteja la información solicitada.

Seguridad pública. El DHS puede divulgar Información Médica si nos lo pide una autoridad de seguridad pública en los siguientes casos: 1) por orden judicial, citación judicial, orden de arresto o procesos similares; 2) cuando se requiere información limitada para identificar o localizar a un sospechoso, fugitivo, testigo esencial o persona desaparecida; 3) cuando se trate de una víctima de un delito, incluso cuando, en algunas circunstancias muy limitadas, no podamos obtener la autorización de la persona; 4) cuando se trate de una muerte que creemos que puede ser el resultado de una conducta ilegal; 5) en caso de conducta ilegal en nuestras instalaciones; y 6) en caso de emergencia para denunciar un delito, la ubicación del delito o las víctimas, o la identidad, la descripción o la ubicación de la persona que cometió el delito.

Forenses, médicos legistas y funerarias. El DHS puede divulgar Información Médica a un forense o médico legista. Esto puede ser necesario, por ejemplo, para identificar a una persona fallecida o para determinar la causa de la muerte. El DHS también puede divulgar Información Médica a funerarias cuando la necesiten para llevar a cabo sus tareas.

Actividades de seguridad nacional e inteligencia. El DHS puede divulgar Información Médica a funcionarios federales autorizados para actividades de inteligencia, contrainteligencia u otras actividades de seguridad nacional autorizadas por la ley.

Servicios de protección para el presidente y otros. El DHS puede divulgar Información Médica a funcionarios federales autorizados para que puedan brindar protección al presidente, a otras personas autorizadas o a jefes de estado extranjeros, o para realizar investigaciones especiales.

Reclusos o personas bajo custodia. Si usted es un recluso en una correccional o está bajo la custodia de una autoridad de seguridad pública, el DHS puede divulgar Información Médica sobre usted a la correccional o a la autoridad de seguridad pública. Esta divulgación se realizaría si fuera necesaria en los siguientes casos: 1) para que la institución le brinde la atención sanitaria, 2) para proteger su salud y seguridad o la salud y la seguridad de otros, o 3) para proteger la seguridad de la correccional.

USOS Y DIVULGACIONES QUE REQUIEREN QUE EL DHS LE DE LA OPORTUNIDAD DE OBJETAR Y OPTAR

Personas que participan en su atención o el pago de su atención. A menos que usted lo objete, el DHS puede divulgar a un miembro de su familia, pariente, amigo cercano u otra persona que identifique Información Médica protegida que se relacione directamente con la participación que tenga esa persona en su atención médica. Si usted no es capaz de aceptar u objetar esa divulgación, el DHS puede divulgar la información cuando sea necesario si se determina que es por su bien de acuerdo con los criterios profesionales del DHS.

Socorro. El DHS puede divulgar su Información Médica protegida a organizaciones de socorro que necesiten su Información Médica protegida para coordinar su atención o notificar a su familia o amigos sobre su ubicación y su estado en caso de desastre. El DHS le dará la oportunidad de aceptar u objetar dicha divulgación cuando sea viable.

SE REQUIERE SU AUTORIZACIÓN PARA OTROS USOS Y DIVULGACIONES

Los siguientes usos y divulgaciones de su Información Médica protegida se realizarán únicamente con su autorización por escrito:

1. Usos y divulgaciones de Información Médica protegida a fines de comercialización.
2. Divulgaciones que constituyan la venta de su Información Médica protegida.

Otros usos y divulgaciones de Información Médica protegida que no cubra este Aviso ni las leyes que se aplican al DHS se realizarán únicamente con su autorización por escrito. Si usted da su autorización al DHS, podrá anularla en cualquier momento presentando una revocación por escrito al funcionario de privacidad mencionado anteriormente. Cuando el DHS reciba la revocación, ya no seguirá divulgando la Información Médica protegida que estaba autorizada. Sin embargo, las divulgaciones que se realizaron de acuerdo con su autorización antes de que la haya anulado no estarán afectadas por la revocación.

SUS DERECHOS:

Tiene los siguientes derechos con respecto a la Información Médica que tiene el DHS:

Derecho a revisar y copiar. Tiene derecho a revisar y copiar la Información Médica que se puede usar para tomar decisiones sobre su atención o el pago de su atención. Esto incluye registros médicos y de facturación, salvo las notas de psicoterapia. Para revisar y copiar esta Información Médica, debe presentar su solicitud por escrito al funcionario de privacidad de HIPAA mencionado anteriormente. El DHS tiene hasta 30 días para poner a su disposición la Información Médica protegida y el DHS puede cobrarle una tarifa razonable por el costo de copiado, envío por correo u otros insumos relacionados con su solicitud. El DHS no le puede cobrar ninguna tarifa si necesita la información para un reclamo de beneficios de conformidad con la Ley de Seguridad Social u otro programa de beneficios estatal o federal basado en necesidades. El DHS puede rechazar su solicitud en algunas circunstancias limitadas. Si el DHS rechaza su solicitud, tiene derecho a pedir que un profesional sanitario licenciado que no haya participado directamente en el rechazo de su solicitud lo revise, y el DHS cumplirá con el resultado de la revisión.

Derecho a una copia electrónica de los registros médicos electrónicos. Si su Información Médica protegida se guarda en formato electrónico (lo que se conoce como registro médico electrónico), tiene derecho a solicitar que se le entregue a usted o a otra persona o entidad una copia en formato electrónico de su registro. El DHS hará todo lo posible por brindarle acceso a su Información Médica protegida en la forma o el formato que usted solicita, si se puede producir fácilmente en esa forma o formato. Si la Información Médica protegida no se puede producir fácilmente en el formato o la forma que usted solicita, se le entregará el registro en el formato electrónico estándar que tengamos. Si no quiere este formato o forma, se le entregará una copia legible en papel. El DHS puede cobrarle una tarifa razonable basada en los costos por el trabajo relacionado con la transmisión del registro médico electrónico.

Derecho a ser notificado en caso de violación de la privacidad. Tiene derecho a ser notificado en caso de que se viole la privacidad de cualquier Información Médica protegida sin autorización.

Derecho a modificar. Si cree que la Información Médica que tiene el DHS es incorrecta o está incompleta, puede pedir al DHS que modifique la información. Tiene derecho a solicitar una modificación durante el tiempo que la información se guarde en nuestra oficina o para nuestra oficina. Para solicitar una modificación, debe presentar su solicitud por escrito al funcionario de privacidad de HIPAA mencionado anteriormente.

Derecho un registro de divulgaciones. Tiene derecho a solicitar una lista de algunas divulgaciones hechas por el DHS de Información Médica con fines que no hayan sido de tratamiento, pago y operaciones sanitarias o que usted haya autorizado por escrito. Para solicitar un registro de divulgaciones, debe presentar su solicitud por escrito al funcionario de privacidad de HIPAA mencionado anteriormente.

Derecho a solicitar restricciones. Tiene derecho a solicitar una restricción o limitación en la Información Médica que el DHS use o divulgue para el tratamiento, pago u operaciones sanitarias. También tiene derecho a solicitar un límite en la Información Médica que divulga el DHS a alguien que participa en su atención o el pago de su atención, como familiar o

amigo. Por ejemplo, puede pedir que el DHS no comparta información sobre un diagnóstico o tratamiento en particular con su cónyuge. Para solicitar una restricción, debe presentar su solicitud por escrito al funcionario de privacidad de HIPAA mencionado anteriormente. El DHS no tiene la obligación de aceptar su solicitud a menos que esté solicitando al DHS que restrinja el uso y la divulgación de su Información Médica protegida a un plan médico para el pago o con fines de operaciones sanitarias y la información que usted desea restringir esté relacionada únicamente con un tema o servicio de atención médica que usted haya pagado completamente de su bolsillo. Si el DHS acepta la solicitud, cumpliremos con su solicitud a menos que la información sea necesaria para brindarle un tratamiento de emergencia.

Derecho a solicitar comunicaciones confidenciales. Tiene derecho a solicitar que el DHS se comunique con usted por cuestiones médicas en una determinada manera o en un lugar en particular. Por ejemplo, puede pedir al DHS que solo se comunique con usted en su trabajo o por correo. Para solicitar comunicaciones confidenciales, debe presentar su solicitud por escrito al funcionario de privacidad de HIPAA mencionado anteriormente. Su solicitud debe especificar cómo o cuándo desea que nos comuniquemos con usted. El DHS cumplirá con todas las solicitudes razonables.

Derecho a una copia en papel de este aviso. Tiene derecho a recibir una copia en papel de este aviso. Puede solicitar una copia de este aviso en cualquier momento. Incluso si aceptó recibir este aviso en formato electrónico, sigue teniendo derecho a pedir una copia en papel de este aviso. Para obtener una copia en papel de este aviso, comuníquese con el funcionario de privacidad de HIPAA mencionado anteriormente.

MODIFICACIONES A ESTE AVISO:

El DHS se reserva el derecho a modificar este aviso y aplicar el nuevo aviso a la Información Médica que ya se obtuvo y a la información que se reciba en el futuro. El DHS publicará una copia del aviso vigente en nuestras oficinas. Este aviso incluirá la fecha de entrada en vigencia la esquina superior derecha de la primera página.

RECLAMOS:

Si cree que se han violado su derecho a la privacidad, puede presentar un reclamo por escrito al funcionario de privacidad de HIPAA mencionado anteriormente. **No se lo castigará por presentar un reclamo.**

También puede presentar un reclamo al secretario del Departamento de Salud y Servicios Humanos. Si desea obtener más información sobre los requisitos de privacidad de la Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPAA), las transacciones electrónicas de conformidad con la HIPAA, y las normas de códigos y las reglas de seguridad de HIPAA propuestas, visite el sitio web de ACOG (Congreso Estadounidense de Obstetras y Ginecólogos), www.acog.org, o llame al (202) 863-2584.

He leído este Aviso de prácticas de privacidad de HIPAA del DHS, lo comprendo y acuso recibo.

Firma

Fecha

Nombre en letra imp

Quick Guide on PE Medicaid Coverage

This document is for informational purposes, only. For applicants, who apply for PE Medicaid with Qualified Hospitals, it explains to them what to expect if their application is approved for the program.

To assist the applicant in keeping abreast of the status of her Medicaid application, this document contains an entry for the telephone number of the RSM/DFCS office. QH should give this document to the applicant, along with other forms required, as part of the application process.

Quick Guide on Presumptive Eligibility Medicaid

Some important things to know about PE Medicaid coverage:

- Your application is being sent to the RSM/DFCS office to finish processing.
- You will be assigned an RSM/DFCS Medicaid Specialist Caseworker. This caseworker may contact you for additional information. Your worker can be contacted at _____.
- You will receive a letter in the mail letting you know whether or not your application is approved for ongoing and/or retroactive Medicaid.
- 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**.

Former FosterCare Medicaid beneficiaries are auto assigned to Amerigroup as your CMO.

- You must report, within 10 days, of **all** household changes. Call the DFCS Call Center at **1-877-423-4746** or on line at www.compass.ga.gov.
- You will have a yearly renewal.
- 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**.

(01/01/2014)

PUT ON OFFICE LETTERHEAD

PRESUMPTIVE ELIGIBILITY CHANGES/CORRECTIONS

FAX TO: HP Member Enrollment
1-866-483-1045

TODAY'S DATE: _____

UPDATE (check one):

PE PREGNANCY
Attach Form 632

PE WHM
Attach Form 632W

PE Medicaid
Attach Form 632H

Name

Address

Residential County Code

Social Security Number

Date of Birth

Duplicate ID Merge: _____ Original _____ Duplicate

Application Date (only if the application date is in another month)

IN ADDITION TO THE ABOVE CHANGE(S) THE ITEMS BELOW ALSO NEED CORRECTED:

Note: If any of the items below are the only correction(s) needed do not fax this form to HP. The information will be updated in GAMMIS when the full Medicaid application is completed.

Administrative County Code

Race: American Indian or Alaskan Asian Black Caucasian

Hispanic Other: _____ (specify)

Ethnicity: Hispanic N/A

Citizenship: U.S. Citizen Qualified Immigrant Non-Qualified Immigrant

Other: _____ (specify)

Expected Birth Date of Fetus

Number of Births

CONTACT INFORMATION:

Name of person completing this form: _____
Please Print Clearly

Direct phone number of person completing this form: _____

CONFIDENTIALITY PROVISION

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee of agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original, message to us at the above address via the U.S. Postal Service. Thank you.

Revised 1/1/14

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

PURPOSE

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

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

PREPARATION

The original copy of newly completed DMA 285's, as well as copies reporting additions, changes, or cancellations are to be mailed to:

Health Management System (HMS)
900 Circle 75 Parkway
Suite 650
Atlanta, GA 30339
OR
Fax: 770-937-0180

The DMA 285 Form should be prepared, dated, and signed by the caseworker and applicant at the initial interview. When reporting information on a TPL, send the completed first page to HMS and retain the two remaining copies in the beneficiary's file. A separate DMA 285 should be prepared and sent for each insurance carrier.

The DMA 285 form can be screen printed from Appendix F or from the GAMMIS website form section. When reporting TPR send the original completed screened printed form to HMS, and keep a photo copy in the file.

If no TPL are reported, do not complete a form DMA 285 if application form DMA 632W with revision date 01/1/13 was used. If an earlier version was used then have the applicant complete the DMA 285 indicating no TPL exist. A new form should be completed when TPL are added or if there is a change in employer related group coverage. Mark "Change" box and show the new information in the appropriate section. If a previously TPL is no longer valid, i.e., is dropped or cancelled, use one of the retained copies of the form and check the "cancellation" block, record the effective date of the cancellation on the line labeled "Policy Termination Date" and send to

EXAMPLE OF FORM DMA 285 COMPLETED:

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

CASE NAME: Applicant's Name CASE NO: N/A (for PE)
 ADDRESS: Applicant's mailing SSN: 123-45-6789
Address PHONE NO: Day time phone number

TYPE OF CASE: INITIAL APPLICATION SPECIAL NEEDS TRUST (SNT) CHANGE CANCELLATION
 (Check all that apply) HIPV REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION: 01/01/XX

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a)(25); 42 CFR 433.133-139). 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) YES NO
 Does your spouse, parent or step-parent have any private, group or government health insurance that pays any of the cost of your medical care? YES NO

Is policyholder an Absent Parent? YES NO

Names of Covered Individuals in Household	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	
(Last) <u>Member</u> (First) <u>Georgia</u> (MI)	<u>111223456789</u>	<u>123-45-6789</u>					<input checked="" type="checkbox"/>	<u>2/11/70</u>

Are any of these persons pregnant? YES NO If yes, Name Georgia Member Date of Delivery 5/22/xx

ATTACH A COPY OF INSURANCE CARD/POLICY AND A COPY OF SNT Do any of the persons listed above have a chronic medical condition? YES NO If yes, Name _____ Condition _____

BCBS (Insurance Company Name) (800) 331-BCBS (Telephone Number)
2 Peachtree Street (Address) Columbus GA 38392 (City) (State) (Zip)
Mr. X Husband Member (Policyholder Name) 987-65-4321 (Policyholder SSN) ABC123 (Policy Number) 04/19/65 (Policyholder DOB)
12/31/00 (Policy Effective Date) ABC Construction (Employer Name) 706-321-5555 (Telephone Number)
211 Maple Drive (Employer Address) LaGrange (City) GA (State) 34567 (Zip)

Types of Coverage (circle those which apply)
 01 - HOSPITAL INPT. 15 - LTCNHR
 07 - DRUGSTND 16 - RMGRDRUG
 08 - MAJOR MED. 17 - MED. SUPP A
 09 - DENTAL 18 - MED. SUPP B
 10 - VISION 22 - TRMGSTND
 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.
 Signed Applicant's Signature Date 01/01/xx
 Member or Authorized Person

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.
 Signed Applicant's Signature Date 01/01/xx
 Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY 01/01/xx
 Case Worker Name Qualified Provider Worker Phone No. Direct Phone County _____

DMA-285-REV. (01-00)

The only items that are required to be completed after a Hospital PE Medicaid approval, that has TPL, are the top part of the form and the two applicant's signatures and date.

**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 (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			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 – HMO/DRUG
08 – MAJOR MED.	17 – MED. SUPP A
09 – DENTAL	18 – MED. SUPP B
10 – VISION	22 – HMO/STND
OTHER _____	

I authorize the release of information necessary to identify health liability insurance benefits to the Department of Community Health. I also certify that the above information is correct.

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.

Signed _____ Date _____
 Member or Authorized Person

Signed _____ Date _____
 Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY _____

Case Worker Name: _____ Phone No: _____ County _____

APPENDIX G - GAMMIS

Sign on to GAMMIS:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

For assistance please contact the [HP Helpdesk](#)

Sign in to the Georgia Medicaid

- Access your applications
- Manage your account
- Change your password
- Submit Authorizations

If you are the Office Administrator authorized by the Provider, register [here](#).

Sign in to Georgia Medicaid [Help](#)

Username:

Password:

Sign In

Georgia Medicaid
Forgot your password?

User Name (points to Username field)

Password (points to Password field)

Get Password (points to Forgot your password? link)

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

For assistance please contact the [HP Helpdesk](#)

Georgia Medicaid Home [Sign Out](#)

Public Health Welcome to Georgia Medicaid

Applications

Application	Description
MEUPS Account Management	Manages contact information, password, and authorizations for applications.
Web Portal	Web Portal Production

Messages
There are no new messages.

To Access the Web Go Here (points to MEUPS Account Management link)

To Change Your Password and Personal Information Go Here. It Takes You Here. (points to MEUPS Account Management link)

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

For assistance please contact the [HP Helpdesk](#)

Account Home [Close Application](#)

[Account Home](#) [My Information](#) [Change Password](#) [Reports](#)

Good Morning Public Health

Please select a button above to view or edit your account.

Password Last Modified: 10/26/2010 11:24:37 AM
Your password will expire in 11 days

Passwords Expire in 60 Days. This Screen Tells You the Days Remaining. (points to password expiration text)

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Going to the Web:



**GEORGIA
WEB PORTAL**



[Refresh session] You have approximately 19 minutes until your session will expire. Tuesday, December 14, 2010

[Home](#) | [Contact Information](#) | [Member Information](#) | [Provider Information](#) | [Provider Enrollment](#) | [Nurse Aide](#) | [EDI](#) | [Pharmacy](#)

[Home](#) | [Publication Search](#) | [Site Map](#) | [Site Settings](#) | [Language Selection](#)

(click to hide) Alert Message posted 12/9/2010

Trading Partner PIN Activation

All Trading Partners (those who submit EDI batch files to Georgia Medicaid) will be receiving a Trading Partner Personal Identification Number (PIN) letter.

If you are a trading partner and you have not received your letter by Sunday, October 24, 2010, then you should contact EDI Services at (770) 325-9590 or toll-free at (877) 261-8785.

Those trading partners who have their PIN letter should [click here to register at our Trading Partner PIN Activation page.](#)

Attention Payees Receiving ERAs.

Important: Provider's enrolled for Electronic Remittance Advices (ERA's) must activate their Payee Provider Web Portal PIN's that they received in the mail.

ERA's are generated using the PAYEE Provider ID; therefore, if you wish to delegate these 835 ERA's so that your clearinghouse/software vendor/billing

(click to hide) Alert Message posted 10/28/2010

Switch User or Switch Trading Partner panel

To begin acting as a particular provider or trading partner, use the Switch Provider or Switch Trading Partner panel below. Once a selection has been made and confirmed, additional menu items will be displayed based on the roles delegated to you.

User Information - Agent PHALLEN ? ⌵

Switch Provider ? ⌵

National Provider ID	<input type="text"/>	Address	<input type="text"/>
Medicaid Provider ID	<input type="text"/>	City	<input type="text"/>
Name	<input type="text"/>	Zip	<input type="text"/>

(2 rows returned)

National Provider ID	Medicaid Provider ID	Provider Type	Name	Address	City	State	Zip	+ 4
		Public Health Agency						
		Public Health Agency						

Select row above to switch to the desired provider.

If you have more than one choice choose your office.

Messages:



**GEORGIA
WEB PORTAL**



[Refresh session] You have approximately 19 minutes until your session will expire. Tuesday, December 14, 2010

[Home](#) | [Contact Information](#) | [Member Information](#) | [Provider Information](#) | [Provider Enrollment](#) | [Nurse Aide](#) | [EDI](#) | [Pharmacy](#)

[Account](#) | [Training](#) | [Claims](#) | [Eligibility](#) | [Presumptive Activations](#) | [Health Check](#) | [Prior Authorization](#)

[Home](#) | [Messages](#) | [Switch Eligibility](#) | [Eligibility](#)

User Information - Provider 000457729N ? ⌵

Messages Top ? ⌵

Category	Subject	Sent Date	Effective Date	End Date	Remove
PROVIDER ALERT	Suspended Claim Attachments	12/01/2010	12/01/2010	12/31/2010	<input type="checkbox"/>
PROVIDER ALERT	EOB / Adjustment Reason / Remark Codes Crosswalk	12/01/2010	12/01/2010	12/20/2010	<input type="checkbox"/>
PROVIDER ALERT	5010 Workshops	11/22/2010	11/15/2010	12/20/2010	<input type="checkbox"/>
NOTIFICATION	Electronic Claims Require Identifying Service Loca	11/15/2010	11/12/2010	12/15/2010	<input type="checkbox"/>

Screening on the web portal:

Always screen on the web first to make sure the applicant is not already active on Medicaid.

The screenshot shows the top navigation bar with links: 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. The 'Eligibility' menu is open, showing options: Newborn Activations, Hospital Activations, Pregnant Women Activations, and Women's Health Activations. Below the menu is a blue bar for 'User Information - Provider 000155933X'. A note states: 'Note: If a member is enrolled in a managed care plan on the date of admission, the plan is responsible for the entire stay as long as Medicaid eligibility is maintained. If the member is enrolled in a fee for service program on the date of admission, then the fee for service program is responsible for the entire hospital stay as long as Medicaid eligibility is maintained. 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 'Eligibility Verification Request' form contains fields for Member ID, Birth Date, Last Name, SSN, First Name, From/Thru Date of Service, Gender, and Service Type (30 - Health Plan Benefit Coverage). Search and clear buttons are present.

If the applicant was ever known to the system, you will see them as inactive at the bottom of the screen.

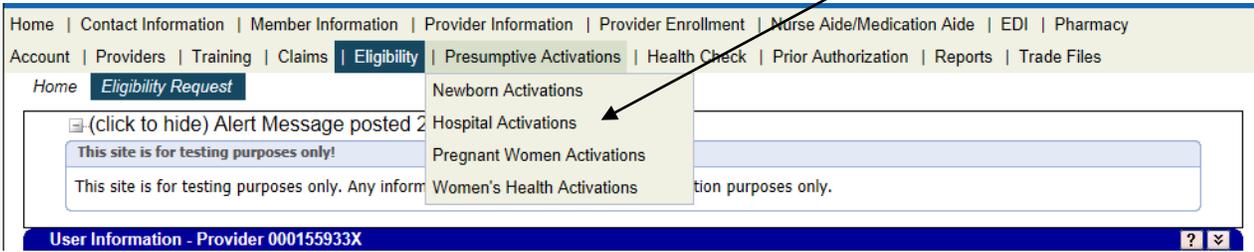
The screenshot shows the 'Eligibility Verification Request' form with the following values: Member ID 111222333444, Birth Date, Last Name, SSN, First Name, From/Thru Date of Service 09/30/20XX to 10/24/20XX, Gender. Below is the 'Member ID Information' section with fields for Member ID (111222333444), Birth Date (12/4/19XX), Address 1 (123 ABC STREET), Address 2(County) (107 - NEWTON), City (COVINGTON), State (GA), Zip (30016-2907), First Name (L.), Last Name (SMITH), Middle Initial (H.), Name Suffix, Gender (F), Transaction Date/Time (10/03/20 02:54:59), and Confirmation # (122770010D). A blue callout box points to the Member ID field with the text: 'Her original Medicaid Number will appear here.' At the bottom is the 'Eligibility Spans' table:

Status	Service Type Code	Insurance Type Code	Aid Category	Effective Date	End Date	Special Notes or Limitations
Inactive				09/30/20	10/24/20	

If they have never had Medicaid this screen will not appear.

If your applicant does not have active Medicaid nor has ever been known to the system you can process her PE application on line.

If your applicant does not have active Medicaid nor has ever been known to the system, you can process the PE application on line. Use the PE tab:



The Hospital PE Screen will appear:

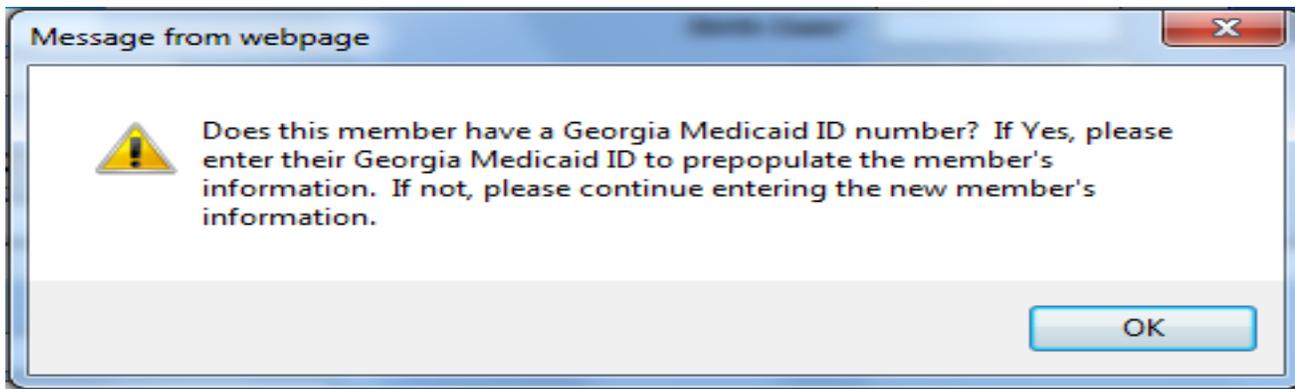
Note: By pressing the submit button, the next page that appears is the member's temporary Medicaid Certificate. You can only print the temporary Medicaid Certificate one time. Please use your browser to print the temporary Medicaid Certificate from the next page. Once you close the temporary Medicaid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

submit cancel

The screenshot shows the 'Presumptive Eligibility for Hospital Request' form. The form is divided into several sections: Household Information, Member Information, Mailing Address, Residential Address, and Eligibility Information. Red arrows point to the following fields: Qualifying Member ID, Net/Taxable Income, Member ID, Number of Adults, Number of Children, Gender, Birth Date, SSN, Home Phone, Other Phone, Ethnicity, Primary Household Language, State, County, Medicaid Application Submitted?, Application Date, Pregnancy Due Date, Determination/Eligibility Begin Date, Denial Reason, and Aid Category. The form also includes a 'submit' button and a 'cancel' button at the top right.

Enter the applicant's original ID number to auto-populate the fields on this panel.

You will be prompted to do so with this alert message:



All information can be changed except the First Name, Date of Birth (DOB) and Social Security Number (SSN). If this information needs to be corrected use the current PE Corrections Coversheet procedure after you enter the PE in the Web.

Once you enter the Member ID number and the submit button you will receive this alert message:



The applicant's last known information in GAMMIS will auto-populate. The Determination/Eligibility Begin Date field will pre-populate with today's date. This field cannot be modified.

Application Date*	<input type="text"/>	
Pregnancy Due Date	09/23/2015	
Determination/Eligibility Begin Date	03/16/2015	

Once all the information is entered on the PE Panel select the Submit button at the top of the screen to finalize the PE application on the Web.

The following messages were generated:

The presumptive eligibility request was successfully processed. The Medicaid ID is 222113132824. 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

The Temporary Medicaid Certificate will appear in a separate box automatically. Print for the member



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH



GEORGIA
WEB PORTAL



GEORGIA
HEALTH
PARTNERSHIP

Welcome. Search

[Refresh session] You have approximately 19 minutes until your session will expire. Wednesday, October 03, 20

Temporary Member Identification Card

Please note: Once the user navigates from this confirmation page, this information will no longer be accessible outside of performing an eligibility request on the member below. Therefore, please use your browser to print this confirmation page before closing.

Thank you for your participation in the Medicaid/PeachCare for KidsSM program. Your presumptive eligibility entry has been received. The Member ID is listed below. This is the number you will need to use when submitting claims for services rendered to this member.

Please check the member eligibility site regularly for updates to this member's eligibility information. You may also access current eligibility information by clicking "Contact Us" under the Contact Information tab in the upper top left of your web screen; or by calling the Provider Contact Center at 1-800-766-4456; or by using the Interactive Voice Response (IVR) System at 1-800-766-4456.

This temporary member identification card may be used as a confirmation of presumptive eligibility for the Medicaid program as of the indicated date. A permanent identification card will be mailed to the member at the address below. Please print this page for the member to use until their member ID card arrives.

A Division of Family and Children Services Medicaid Eligibility Specialist will contact the member about her eligibility. Rx BIN Number 003858

Eligibility Verification Request

From/Thru Date of Service: 09/01/20 - 10/31/20

Member ID Information

Member ID		First Name	
Birth Date		Last Name	
Address 1		Middle Initial	
Address 2(County)		Name Suffix	
City		Gender	F
State		Transaction Date/Time	10/03/20 03:43:02
Zip		Confirmation #	1227700132

Eligibility Spans

Status	Service Type Code	Insurance Type Code	Aid Category	Effective Date	End Date	Special Notes or Limitations
Active	30-Health Benefit Plan Coverage	MC-Medicaid	865 - Presumptive Preg. Woman	09/01/20	10/31/20	THIS IS A PRESUMPTIVE ELIGIBLE MEMBER. INPATIENT HOSPITAL AND DELIVERY PROCEDURES ARE NOT COVERED

Appendix I - Income

Revised
7/1/16

2499 – TREATMENT OF INCOME IN MEDICAID

Use the chart below to determine the following treatment for a specific type of income:

- Whether the income is included (I) or excluded (E) in the Medicaid eligibility budgets for ABD and Family Medicaid and patient liability/cost share budgets
- Whether the income is earned or unearned
- Specific verification requirements, if any.

NOTE: If specific verification requirements are not listed, verify the income from the source.

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ACCIDENT OR HEALTH PLAN	Unearned- the value of accident or health plan coverage provided by an employer.	E(MAGI and Non MAGI)	
	Long Term Care Coverage -contributions by an employer to provide coverage for long-term services. This includes Archer MSA contributions.	E(MAGI and Non MAGI)	
	Health Flexible Spending Arrangement (health FSA) -employer provided health FSA which will result in a reduction of salary and reimbursements of medical care.	E(MAGI and Non MAGI)	
	Health Savings Accounts (HSA) -contributions made by the individual are deductions for tax returns.	E(MAGI and Non MAGI)	
	Distributions from HSA that are used to pay medical expenses.	E(MAGI and Non MAGI)	
	Distribution from HSA that are not used to pay medical expenses.	E(MAGI and Non MAGI)	
	Contributions to HSA made by employers	I(MAGI and Non MAGI)	
	Qualified HAS funding distribution-a onetime distribution from an individual retirement account (IRS) to an HAS.	E(MAGI and Non MAGI)	

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ADOPTION ASSISTANCE	Unearned – Payment received for the adoption of certain children.	E(MAGI and Non MAGI)	E
IV-E	Exclude as income.	E(MAGI and Non MAGI)	E
IV-B	Exclude as income.		
ADVANCE	Unearned – Money for future expenses that does not represent a gain to the AU. Earned – A prepayment of wages or salaries.	E(MAGI and Non MAGI) I(MAGI and Non MAGI)	E I
AGENT ORANGE PAYMENTS	Unearned – A payment made to a Vietnam Veteran who was exposed to Agent Orange defoliant. The payment is made to the surviving spouse and children.	E(MAGI and Non MAGI)	I
ALASKA NATIVE CLAIM	Unearned – Payments made under Alaska Native Claims Settlement Act. Alaska Permanent Fund Dividend-payment from Alaska’s mineral income fund.	E (MAGI and Non MAGI) I(MAGI and Non MAGI)	I I
ALIMONY/ SPOUSAL SUPPORT	Unearned – A court-ordered payment from an estranged spouse or former spouse to the other spouse for support under the terms of a court order or settlement agreement following a divorce. Payments may be in one lump sum, or in a series of monthly payments. Alimony is also termed “spousal support” or “maintenance”.	I(MAGI and Non MAGI)	I
AMERICORPS	Income from Americorps Network of programs which encompasses: Americorps USA Americorps VISTA Americorps NCCC Are handled as specified below:		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	Living Allowance Stipend – Earned Income	E (Non MAGI) I (MAGI)	E
	On-the Job Training – Earned Income	E (Non MAGI) I (MAGI)	E
ANNUITY	Unearned – Recurring payment received from an investment. Refer to Section 2339 , Trust Property, Annuities.	I(MAGI and Non MAGI)	I
ASSISTANCE BASED ON NEED (ABON)	Unearned – assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a state or local government.	E(MAGI and Non MAGI)	E
BLACK LUNG BENEFITS	Unearned – benefits paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act. Phone number for United Mine Workers is 1-800-654-9763.	I (Non MAGI) E (MAGI)	I
BLOOD, sale of	Earned – Money received from the sale of blood including blood products.	I(MAGI and Non MAGI)	I
BOARDER INCOME	Earned – Direct payments for food and related shelter expenses, less the cost of doing business.	I(MAGI and Non MAGI)	I
BONUS	Earned – Wages paid in addition to the usual or expected wages. Refer to Wages in this chart.	I (MAGI and Non MAGI)	I
CAPITAL GAINS	Earned or Unearned – profits from the sale of capital goods or equipment. Capital assets are resources such as stock, securities, real estate and equipment that are typically held as an investment for a period of time. A capital gain is realized when the item(s) sold have appreciated in value from the original purchase price.	I(MAGI and Non MAGI)	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CENSUS INCOME	Earned- All wages paid by the Census Bureau for temporary employment related to Census activities.	E (MAGI and Non MAGI)	E
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATION NOT STATE/ FEDERALLY FUNDED	Unearned – Charitable donation paid to the AU or BG.	E(MAGI and Non MAGI)	E
CHARITABLE DONATION FROM FEDERALLY OR STATE FUNDED ORGANIZATION	Unearned – Charitable donation paid to the AU or BG from organizations receiving state or federal funds. For example: Salvation Army, United Way, Catholic Charities, and Lutheran Social Service Agencies.	I(MAGI and Non MAGI)	I
CHILD CARE ATTENDENT (wages earned by)	<p>Earned – income received for providing child care services.</p> <p>Consider the income as follows:</p> <ul style="list-style-type: none"> • Self-employment if the attendant provides child care services in his/her home <p>As wages if the attendant provides services in the home of the child.</p>	I(MAGI and Non MAGI)	I
CHILD CARE PAYMENTS	Unearned – Payments made under Title IV of the Social Security Act to a child care provider on behalf of the AU. These payments include Transitional Child Care, and At Risk block grant child care payments made under P.L 101-508, Section 5801 of the Social Security Act.	E(MAGI and Non MAGI)	E
CHILD NUTRITION PAYMENTS	<p>Unearned – The value of meals provided to a child in day care through the Child Nutrition Amendment of 1978.</p> <p>* If the payment is for a child of the attendant, budget the entire amount as</p>	*I(MAGI and Non MAGI)	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<p>unearned income.</p> <p>If the payment is for any other child, treat as self-employment income.</p> <p>Refer to the Section 2415, Self Employment.</p>		
CHILD SUPPORT	<p>Unearned – Income received for the support of child (ren) from the non-custodial parent of the child. Child support paid for a child by a non-custodial parent is always income to the child and never to a parent/ relative/ guardian.</p> <p>*If an ABD Medicaid child (including LA-D A/Rs) receives child support from a non-custodial parent exclude from the eligibility budget 1/3 of the monthly child support received.</p>	<p>I (ABD) E (MAGI) I (Non MAGI)</p>	I
CHILD'S EARNINGS Children in Placement	<p>Earned – Income earned by a child, including MAGI Medicaid under 19 years old and for CW-FC children to 21 years.</p> <p>*Refer to Section 2610 to determine when Child's Earnings should be counted.</p> <p>Reference Section 2835, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria for children in care.</p>	<p>I (ABD) E* (MAGI and Non MAGI)</p>	E
CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS	<p>Unearned – income paid by the U.S. Civil Service and Federal Employee Retirement System (FERS) through the Office of Personnel Management (OPM) because of disability, retirement or death. NOTE: Certain disability benefits paid within the first 6 months that an employee last worked are earned income.</p> <p>Use notices or other documents in the individual's possession (other than a check) to verify the gross amount of</p>	I (MAGI and Non MAGI)	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
<p>CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS (cont'd)</p>	<p>the payment. Notices providing the amount of the annuity and the adjusted amount of the annuity are reliable evidence of the gross amount. If an individual's records are unavailable, complete Form 990, Benefits Verification, and direct the inquiry to the following address:</p> <p>Office of Personnel Management Retirement and Insurance Coverage 1900 E. Street, NW Washington, D.C. 20415</p>		
<p>COMMISSION</p>	<p>Earned – A payment, usually a set fee or percentage, made to an employee for his/her service in facilitating a transaction such as buying or selling goods. A commission may be paid in lieu of or in addition to a regular salary. Refer to Wages in this chart. If the payment is recurring, include it when determining representative pay. If not, do not include the pay. Refer to Section 2653, Prospective Budgeting.</p>	<p>I (MAGI and Non MAGI)</p>	<p>I</p>
<p>CONTRACTED EMPLOYMENT INCOME</p>	<p>Earned – Income received from jobs in which there is a contract or payment agreement. Determine the gross monthly amount by dividing the total amount during the life of the contract by the number of months specified in the contract.</p>	<p>I</p>	<p>I</p>
<p>CONTRIBUTION, GIFT, PRIZE, AWARD</p>	<p>Unearned – Money given to the AU as a gift from individuals or organizations.</p> <p>*ABD: If the contribution is in the form of food, clothing or shelter, value the contribution as ISM, including third party vendor payments resulting in food, clothing, or shelter to the A/R.</p> <p>EXCEPTION: Never include ISM as income for an A/R in LA-D.</p>	<p>*I (ABD and Non MAGI) E (MAGI)</p>	<p>I</p>
<p>DEATH BENEFITS</p>	<p>Unearned – a benefit received as the result of another's death, such as the following:</p>	<p>*I (MAGI and Non MAGI)</p>	<p>*I</p>

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> • Cash or in-kind gifts given by relatives, friends, or a community group to “help out” with expenses related to the death • Inheritances in cash or in kind • Lump sum death benefits from SSA • Proceeds of life insurance policies received due to the death of the insured • RR Retirement burial benefits • VA burial benefits <p>NOTE: Recurring survivor benefits such as those received under Title II (RSDI), private pension programs, etc., are not death benefits.</p> <p>* Death benefits provided to an individual are income to the individual to the extent that the total amount exceeds the expenses of the deceased person’s last illness and burial paid by the individual.</p> <p>Last illness and burial expenses include related hospital and medical expenses; funeral, burial plot, and interment expenses; and other related expenses. Verify all last illness and burial expenses. If verification (e.g., bills, receipts, contact with provider, etc.) cannot be obtained, accept the individual’s signed allegation. If an expense has been incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No follow-up is required if the assumption is applied.</p> <p>Use judgment to determine whether an expense is reasonably related to the last illness and burial. It is expected that related expenses may include such items as new clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc</p>		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
DEEMED INCOME	<p>Unearned – A portion of income of a non- AU or BG member that is applied to the AU.</p> <p>* For ABD Medicaid, there is no deeming in Patient Liability/Cost Share determinations.</p>	I	*
DEFERRED COMPENSATION PLAN	UNEARNED- Money paid regularly from a deferred compensation plan. The money is usually available upon the owner's employment retirement or if the owner attains a certain age.	I(MAGI and Non MAGI)	I
DISABILITY	Unearned – Paid by insurance company or a source other than an employer. Refer to Sick Pay in this chart.	E-MAGI I-Non MAGI	I
DISASTER ASSISTANCE (Presidentially Declared)	Unearned – Government payments for restoration of a home damaged by a disaster.	E	E
DISASTER UNEMPLOYMENT ASSISTANCE	UNEARNED- Unemployment benefits paid to an AU member during a major disaster or catastrophe.	E (ABD and Non MAGI) I (MAGI)	E
DIVERTED INCOME FOR FAMILY MEDICAID	Unearned – Money deducted or diverted by a court order to a third party.	E	N/A
Children in Placement	<p>Unearned – Money that is legally obligated to an AU member by a court order but is diverted at the option of the AU member to a third party.</p> <p>Benefits/support (child support, SSI, RSDI, etc.) of a child in care diverted to the county of custody as designated payee for the benefit and care of the child and are considered the child's benefits/support. Refer to specific type of income for treatment of income.</p>	I	N/A N/A
DIVERTED INCOME FOR ABD MEDICAID	Unearned - Income diverted to a spouse or dependent family member from a NH or CCSP A/R.	I	I
Spouse or Dependent Family Member	Include as unearned income to the spouse or dependent family member		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
A/R	<p>(DFM) to whom the income is diverted in the eligibility and CCSP/ICWP cost share budgets, if the spouse /DFM is a Medicaid A/R. Refer to Section 2554, Diversion of Income.</p> <p>Include as unearned income to the A/R from whom the income is diverted in the eligibility budget. Allow as a patient liability/cost share budget deduction. Verify from the NH, CCSP or A/R's case record. EXCEPTION: Diverted income is included in PL when a community spouse enters LA-D. Refer to Spousal Impoverishment budgeting.</p>	I	E
DIVIDENDS	<p>Unearned – A share of profits received by a policy holder or shareholder.</p> <p>NOTE: Any dividends left to accrue are a resource separate from the resource that is earning dividends.</p> <ul style="list-style-type: none"> • For ABD Medicaid, any dividends earned on countable resources are not counted as income. • For non-FBR COAs, dividends earned on excluded life insurance policies are excluded as income. <p>*For Family Medicaid, dividends earned on life insurance policies are a countable resource.</p> <p>NOTE: Non-participating life insurance policies do not earn/pay dividends. Use Form 106 or other acceptable documents to verify dividends.</p>	*E	*E
DOMESTIC VOLUNTEER SERVICES PAYMNTS	Unearned – Payments to volunteers under the federal government program	E	I
EARNED INCOME TAX CREDIT (EITC)	Unearned – A special tax credit which reduces the federal tax liability of	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<p>certain low income working taxpayers. This tax credit may or may not result in a payment.</p> <p>EITC payments can be received as an advance from an employer or a refund from IRS.</p> <p>EITC given as a tax credit (no payment) is not income.</p>		
<p>EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS (Title IV of Higher Education Act Programs)</p>	<p>UNEARNED- Payments for the educational assistance of an AU member enrolled at a recognized institution of post-secondary education, school for the handicapped, vocational program or a program that provides for completion of a secondary school diploma or GED. These programs include Pell grants, State Student Incentive Scholarships, Work-Study programs, etc.</p> <p>Unearned – payments from educational assistance to the A/R. Exclude, regardless of use.</p>	<p>E (ABD, MAGI and Non MAGI)</p>	<p>E</p>
<p>EMERGENCY ASSISTANCE (IV-A)</p>	<p>Unearned – payments for children, including families with children, provided by the state and matched with federal funds. Emergency Assistance is used to meet emergency needs and is not IBON or ABON.</p> <p>NOTE: Georgia does not provide Emergency Assistance payments.</p>	<p>I</p>	<p>I</p>
<p>EMPLOYEE RETIREMENT BENEFITS</p>	<p>Unearned – Individuals/surviving spouse may be eligible for retirement benefits based on previous employment.</p> <p>Explore if the A/R or spouse worked 10 or more years for the same employer.</p>	<p>I</p>	<p>I</p>

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ENERGY ASSISTANCE PAYMENTS	Unearned – Payment or allowance received under federal, state, and local law for the purpose of assisting the AU with the cost of heating and cooling its home. These include HUD and FMHA Utility reimbursements.	E	E
FARM ALLOTMENTS	Unearned – Payments from government sponsored programs such as Agricultural Stabilization and Conservation Services which are a gain or a benefit to the AU.	I	I
FARMING	Earned – Income received from agricultural labor. Refer to Section 2415, Self Employment .	I	I
FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS	Unearned – food and shelter assistance provided in cash or in kind in emergency disaster situations. Exclude if the assistance is designated as home energy assistance or support and maintenance assistance. Otherwise, contact the State Medicaid Unit for further instructions.	E	E
FEDERAL PROGRAMS, MISCELLANEOUS	<ul style="list-style-type: none"> • Federal Housing Assistance • Food Stamps • Food Programs with federal involvement for Older Americans • Refugee Cash Assistance, Cuban and Haitian • Entrant Cash Assistance and federally reimbursed general assistance payments to refugees • Refugee reception and placement grants and refugee matching grants • Relocation Assistance <p>NOTE: Contact the State Medicaid Unit if there is a payment that is not on this list and it is questionable as to whether it should be excluded or counted.</p>	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
FLEXIBLE BENEFITS	Earned – Refer to Wages in this chart.	I	I
FOSTER CARE PAYMENTS (IV-B or Title XX)	Unearned – per diem payments received by the foster parents to provide for the needs of the foster child and foster family.	E	E
FOSTER CARE PAYMENTS (IV-E)	Unearned – per diem payment received to provide for the needs of the foster child. Exclude as income to the foster child.	E	E
FOSTER GRANDPARENTS PROGRAM PAYMENTS	Unearned – payments received for voluntary service under the federal government (ACTION)	E	I
GARNISHMENT	Earned/Unearned – A set amount of wages or monies withheld by an employer/entity to pay a debt owed to a third party.	I	I
GUARDIANSHIP, ENHANCED SUBSIDIZED AND SUBSIDIZED	Financial support for a child who was in the custody of DHR and guardianship is awarded to a relative or non-relative foster parent(s). Income is not attributed to the child. Reference Section 2848 – Relative Care Placement for additional information.	E	E
GENERAL ASSISTANCE (GA) PAYMENTS	Unearned – payments received by the A/R from county funds administered by DFCS. Consider as Assistance Based on Need (ABON).	E	E
GENERAL ASSISTANCE VENDOR PAYMENTS	Unearned – GA paid directly to the provider if paid for housing expenses including GA paid for transitional housing for the homeless and if paid for energy or utilities.	E	E
GRANDPARENTS RAISING GRANDCHILD-REN	TANF lump sum payment in the amount of three times the eligible grant amount for the AU size.	ABD-I* FM-E	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EMERGENCY/ CRISIS INTERVENTION SERVICES	This payment is used to help pay for the cost of emergent needs incurred by the grandparents when the children come to live with them. *For ABD Medicaid, do not deem GRG income of the A/R's parent or spouse to the A/R.		
GRANDPARENTS RAISING GRANDCHILD-REN SUBSIDY PAYMENT	UNEARNED-TANF Subsidy in the amount of \$50.00 per child per month used assist low income (fixed income) grandparents (60+) to cover additional expenses associated with rearing their grandchildren. *For ABD Medicaid, do not deem GRG income of the A/R's parent or spouse to the A/R.	ABD-I* FM-E	I
GRANDPARENT PAYEE	* The Grandparent payee's income is not counted in the TANF budget. The children's TANF income is not counted in the Grandparent Payee's ABD Medicaid budget	*	*
HEALTH REIMBURSEMENT ACCOUNT	An account through an employer which may only be used to reimburse individuals for certain medical services. * Count any income received in excess of the incurred expense(s) as unearned income.	*E	*E
HOME PRODUCE	Unearned–home produce used for personal consumption and not offered for sale.	E	E
HOUSING AND DEVELOPMENT (HUD) RENTAL REFUND	Unearned – Payment received by the AU for rent. Payments are often distributed by the Georgia Residential Financial Authority (GRFA). Payments can be made directly to the AU, by a two-party check or directly to the landlord on behalf of the AU.	E	E
HOUSING AND URBAN DEVELOPMENT (HUD) OR FARMERS HOME ADMINISTRATION	Unearned – Utility reimbursement provided by HUD and FMHA to AUs who receive housing assistance and are responsible for paying their utilities separately from their rent.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
(FMHA) UTILITY REIMBURSEMENT	Payments can be paid directly to the AU, by a two-party check or directly to the utility company on behalf of the AU.		
INCOME BASED ON NEED (IBON)	<p>Unearned – Assistance provided under a program that considers other income as a factor in determining eligibility and is funded wholly or partially by the federal government or a non-governmental agency for the purpose of meeting basic needs (TANF, SSI, VA Pension, etc.).</p> <p>Continued next page.</p>	See specific type of IBON	See specific type of IBON
INCOME BASED ON NEED (IBON) (cont.)	NOTE FOR ABD: Do not allow the \$20 general exclusion to IBON. Do not deem IBON received by the A/R's spouse or parent to the A/R.		
INCOME TAX REFUND	*Refer to the Chapter 2300, Resources, to determine how to count income tax refunds. For how to count in PL/CS, refer to Section 2552, PL/CS Deductions .	*	*
INDIAN LAND GRANTS	Unearned – Federal distributions to members of Indian Tribes.	E	E
INDIAN GAMBLING ACT PAYMENTS	<p>Tribally managed gaming revenues</p> <p>* If the funds have NOT been held in trust by the Secretary of the Interior, count as unearned income. If held in trust by the Sec. of Interior, exclude.</p>	*	*
INHERITANCE	<p>Unearned– cash, a right or non-cash item(s) received as a result of someone's death.</p> <p>Exclude expenses for the last illness & burial of the deceased if paid by the inheritor.</p> <p>NOTE: Until an item or right has a value or is accessible, it is neither income nor a resource.</p>	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
IN-KIND ITEMS RECEIVED IN LIEU OF WAGES	Earned – Wages may include the value of food, clothing, shelter or other items provided in lieu of cash wages.	I (ABD) E (MAGI and Non MAGI)	E
IN-KIND SUPPORT AND MAINTENANCE	Unearned – Any gain or benefit that is not in the form of money payable directly to the AU such as meals, clothing, produce or housing. * Refer to Section 2430 , Living Arrangements and In-Kind Support and Maintenance.	*I (ABD) E (MAGI and Non MAGI)	E
INSURANCE BENEFITS DUE TO LOSS OF INCOME	Unearned – benefits paid from an insurance policy due to loss of income. * Refer to Section 2230 , Third Party Resources, for information on benefits paid to cover medical expenses.	*I	*I
INTEREST	Unearned – Income paid from bank account deposits, life insurance or other financial instruments/investments. FAMILY Medicaid: Annualize for prospectively budgeted AUs to determine a monthly amount. *Exclude amounts of \$1.00 or less per month. ABD Medicaid: The following types of interest earned on countable resources are excluded as income in the eligibility and PL/CS budgets: <ul style="list-style-type: none"> • Interest earned on all countable financial instruments, such as checking/savings accounts, CDs, etc. • Interest earned on countable Patient Fund Accounts. *Exception: Interest portion of payment made on contracts are counted as income. *NOTE: If total interest earned on excluded resources is \$20/month or	Family *I ABD-E*	E*

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	less, exclude in the Medicaid eligibility and AMN spenddown budgets. If total interest earned on excluded resources exceeds \$20/month, include all the interest in the eligibility and spenddown budgets. See exceptions below.		
INTEREST Burial Contracts	Exclude interest earned on the excluded portion of a burial contract for FBR A/Rs.	E	E
Burial Funds	Exclude all interest earned on a burial contract for non-FBR A/Rs if left to accrue.	E	E
	Exclude interest earned on the excluded portion of funds set aside for burial for FBR A/Rs.	E	E
	Exclude interest earned on the first \$5000 of funds set aside for burial for non-FBR A/Rs if left to accrue.	E	E
INTEREST Dividends	Exclude interest earned on the dividend accumulations from excluded life insurance policies for ABD Medicaid non-FBR A/Rs.	E	E
	For Family Medicaid include interest earned on life insurance policies, stocks and mutual funds.	I	I
	For ABD Medicaid exclude as income dividends/interest earned on countable resources such as stocks and mutual funds.	E	E
IRREGULAR/ INFREQUENT INCOME	Earned and Unearned – Income that is received too infrequently or irregularly to be anticipated, regardless of the amount. Refer to Section 2504 for definition of irregular or infrequent income. Treat such income as the following:		
	<ul style="list-style-type: none"> Earned income of \$30 or more received over a three month period Earned income of less than \$30 received over a three month period 	I E-ABD I-Family E-ABD	I I I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> Unearned income of less than \$60 received over a three month period Unearned income of \$60 or more received over a three month period	I-Family I	I
JAPANESE – AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS (PL 100-383)	Unearned – Restitution payments made by the U.S. Government to Japanese-Americans and Aleutians or their survivors as a consequence of their evacuation, relocation and internment during World War II.	E	E
JURY DUTY	Earned – Compensation received for serving on a jury.	I	I
LOANS FROM OTHERS (PERSONAL OR BUSINESS): A/R is making payments	Unearned – Money received that the borrower has an obligation to repay. Requires a prepayment agreement (written or oral).	E	E
LOANS TO OTHERS (Payment made to A/R)	Unearned - Money loaned to persons outside the AU where a repayment agreement exists. Payments received are considered income. * ABD Medicaid refer to Section 2313 .	I *	I*
LOTTERY WINNINGS	Unearned – A sum of money received as a result of purchasing a winning ticket in a game of chance. * Refer to the appropriate sections on Lump Sum budgeting for Family Medicaid or ABD Medicaid.	*	*
LUMP SUM Children in Placement	Unearned – A sum of money that is received at one time. This may be an accumulated amount or a one-time occurrence. * Count as income in month of receipt. Any remainder is counted as a resource beginning the month after receipt (refer to Resources Chart 2399.1, Lump Sums). For all AFDC related categories of Medicaid, a lump sum is treated as income in the month received and as a resource in any amounts thereafter.	*	*

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
MANAGED INCOME	<p>Unearned – Money legally due the AU that is paid to a protective payee even if the payee is not a member of the AU or resides elsewhere.</p> <p>***** *****</p> <p>Unearned – Money received by the AU for the care and maintenance of an individual not in the AU.</p> <p>Include as income to the individual entitled to the income. Exclude as income to the protective payee.</p> <p>NOTE: Exclude as income to the AU if the protective payee is not making payments to or for the AU.</p>	<p>ABD – I</p> <p>FM – I</p> <p>***** *****</p> <p>ABD – I</p> <p>FM – I</p>	<p>I</p> <p>***** *</p> <p>I</p>
MILITARY ALLOTMENTS	<p>Unearned – payments received for quarters, rations, and clothing are subject to deeming.</p> <p>In ABD Medicaid, Furnished on-post housing is subject to the PMV rule as ISM but is not subject to deeming.</p> <p>In Family Medicaid, consider the income as child support if for a dependent child. Only base pay is earned income.</p>	I	I
MILITARY PAY	<p>Military personnel benefits as reported on Leave and Earnings Statement (LES). Refer to Section 2420, Military Pay.</p>	I	I
MILITARY RETIREMENT	<p>Unearned – income received by military retirees and survivors. Beneficiaries who may be entitled to receive military payments include the retiree, his/her surviving spouse and children.</p> <p>Direct inquiries to :the Military Finance Centers as shown below:</p> <p>Air Force Parallel FO: 388 AFAFC/XSP Denver, CO 80279</p> <p>Army</p>	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EMPLOYMENT PROGRAM	than a wage or salary is excluded income.		
OVERTIME PAY	EARNED- Extra income paid to employees who work in excess of 40 hours in a week. Refer to Wages in this chart.	I	I
PENSIONS	Unearned – A payment received regularly as a retirement benefit.	I	I
PUBLIC LAW 103-286 - PAYMENTS to VICTIMS of NAZI PERSECUTION (examples, including but not limited to the following: German Reparation, German Pensions for Work in Ghettos	Unearned – any payments made to individuals because of their status as victims of Nazi persecution under Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 Such payments are disregarded in determining eligibility for any amount of benefits/services provided under any Federal or federally assisted program based on need,.	E	E
Qualified Income Trust (QIT)	Income placed in a QIT allows for income eligibility under ABD LA-D COAs. Refer to Section 2407.	Family – N/A ABD LA-D COAs – E All other ABD COAs – N/A	I
Qualified Tuition Savings Programs (529 Plans)	A savings plan for higher education Refer to Section 2344 .	E	E
RAILROAD RETIREMENT (RR)	Unearned – retirement, survivors or disability income paid to former railroad employees and /or their dependents. Use gross RR and/or RSDI, including the amount paid as a Medicare premium. * For ABD Medicaid, refer to Section 2552 , Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost	I	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RAILROAD RETIREMENT (RR) (cont'd)	<p>share budget.</p> <p>Consider a benefit augmented for dependents as income to the beneficiary, not the dependent.</p> <p>If the A/R's SSN begins with a 7, the individual is likely to be eligible for RR.</p> <p>If the A/R's deceased spouse worked for a railway system, the A/R may be eligible, even if remarried.</p> <p>RSDI and RR may be combined in one check. If so, verify RSDI via SSA and RR through the Railroad Retirement Board.</p> <p>To obtain written verification of the benefit amount, complete Form 990 and mail to:</p> <p>Benefits Verification Railroad Retirement Board 401 W. Peachtree Street, Room 1702 Atlanta, GA 30365-2550</p>		
REFUNDS FROM DCH	Unearned – A refund of excess proceeds from a TPL after Medicaid and the TPL have paid a medical expense claim in full.	I	I
REIMBURSEMENT	Unearned - Payment for an expense that does not represent a gain or benefit to the AU.	E	E
RELATIVE CARE SUBSIDY	Unearned - Financial support for children placed with an approved relative caregiver. A child may or may not be in DFCS custody for relative caregiver to qualify for certain subsidies.	E	E
RELOCATION ASSISTANCE	Unearned – Money paid under Title II of the Uniform Relocation Assistance & Real Property Acquisition Policies Act of 1970.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RENTAL INCOME	<p>Earned or unearned – Money received on property owned by an AU member and rented to others.</p> <p>Earned – Must be engaged in management of property an average of 20 hours per week.</p> <p>Unearned – If not involved in management more than 20 hours per week.</p>	I Family-May deduct expenses from maintaining and handling of property	I May deduct expenses from maintain-ing and handling of property
REPAYMENT OF OVERPAYMENT OF BENEFITS THROUGH BENEFIT REDUCTION IN TANF, SSI, RSDI, UCB (or others)	<p>FAMILY MEDICAID: Unearned – Money withheld from the income source to repay a previous overpayment.</p> <p>Do not count the repayment amount. Count the gross minus the repayment amount.</p> <p>* ABD MEDICAID: Refer to RSDI Recoupment Amount and SSI Recoupment Amount in this chart.</p>	FM – E ABD - *	*
RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)	Unearned – A federal volunteer services program.	E	I
RETIREMENT	Unearned – A sum of money paid regularly as a retirement benefit.	I	I
RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI) (Also referred to as TITLE II BENEFITS or Social Security Benefits)	<p>Unearned – Social Security benefits paid to an insured worker or dependent on the basis of the retirement, death or disability of the worker.</p> <p>Use the gross entitlement (before the Medicare Part B premium is deducted) in the eligibility budget.</p> <p>* For ABD Medicaid, refer to Section 2552, Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget.</p>	I (Non-MAGI) I* (MAGI)	I*

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
<p>RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI) (Also referred to as TITLE II BENEFITS or Social Security Benefits) (cont'd)</p>	<p>Count the entire RSDI lump sum payment as income for the month of receipt.</p> <p>NOTE: Refer to Chart 2399.2 – Resource Treatment of Income Retained after the Month of Receipt, for instructions on how to treat any portion of a RSDI lump sum retained after the month of receipt.</p> <p>Do not count refunded Medicare Part B premiums as unearned income.</p> <p>*For MAGI COAs RSDI of a tax dependent/child who has no other source of income AND resides with a parent is excluded. RSDI for a tax dependent/child is countable only if the tax dependent/child has other income that meets the IRS tax filing threshold or if the child does not reside with a parent and is not claimed as a tax dependent by his/her parent. Refer to Section 2610.</p>	<p>I (Non-MAGI) I* (MAGI)</p>	<p>I*</p>
<p>REVERSE MORTGAGE</p>	<p>Unearned – allows a homeowner to borrow, via a mortgage contract, a portion of the appraised value of the home. The homeowner then receives a periodic payment (or a line of credit) which does not have to be repaid as long as the borrower lives in the home. Reverse Annuity Mortgages (RAMs) involve the purchase of an annuity. In most reverse mortgages, the original loan does not need to be repaid until the homeowner dies, sells the home, or moves.</p> <p>The HEC plans connected with HUD through the Federal Housing Authority are reverse mortgages.</p> <p>Treat as loan proceeds</p> <p>Annuity payments from a RAM</p>		

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EARNINGS (NET)	Refer to Section 2415, Self-Employment .		
SENIOR COMPANION PROGRAM	Unearned – payments to volunteers under a federal government program	E	I
SEVERANCE PAY	Earned – Money received from former employer upon termination of employment. Unearned- payments received from a former employer after termination of employment.	I	I
SHARED HOUSEHOLD EXPENSES	Payments made to an AU by a person who shares household expenses, and which do not represent a gain or benefit to the AU. Consider UNEARNED income for Family Medicaid. Refer to Section 2430, In-Kind Support and Maintenance , for ABD Medicaid.	E	E
SHELTERED WORKSHOP / WORK ACTIVITY CENTER PAYMENTS	Earned – payments received for work performed in a sheltered workshop or work activity center.	I	I
SICK PAY	Sick Pay is a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability. Unearned – Any payments for sickness and accident disability paid more than 6 months after work stopped because of sickness or disability or sick payments made from the employee's own contributions are unearned income.	I I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
SICK PAY (cont'd)	<p>Earned – If paid from employer's payroll.</p> <p>Unearned – Paid by insurance company or a source other than an employer.</p>	<p>I</p> <p>E (MAGI) I (Non MAGI)</p>	
SPECIAL AND DEMONSTRATION VOLUNTEER PROGRAMS	Unearned – Payments to volunteers under a federal government program	E	I
SPENDING ACCOUNT	EARNED-Pre-taxed earnings that are deducted from an employee's gross wages and placed in an account to pay AU expenses such as childcare and medical costs.	I	I
STRIKE BENEFITS	Unearned – Income received by individuals on strike.	I	I
SUPPLEMENTAL SECURITY INCOME (SSI)	<p>Unearned – monthly payments made to aged, blind or disabled individuals from the federal government. SSI is administered by the Social Security Administration. Consider as Income Based on Need (IBON). SSI recipients also receive Medicaid.</p> <p>* For ABD Medicaid, do not deem the ineligible parent or spouse's SSI income to the A/R. However, include SSI in the Couple eligibility budget when one member of the couple is AMN and the other receives SSI.</p> <p>** Refer to Section 2578, SSI Recipients, for information on including SSI income in nursing home patient liability budgets.</p>	<p>ABD-*I</p> <p>FM – E</p>	**I
SSI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly SSI or RSDI check by SSA to recover an overpayment of SSI benefits to the individual.	<p>ABD – I</p> <p>FM – E</p>	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> Exclude a SSI recoupment from a SSI check, but include a SSI recoupment from an RSDI check, in the patient liability budget. <p>For Family Medicaid, refer to Repayment of Overpayment of Benefits through Benefit Reduction in TANF, SSI, RSDI, UCB or others on page 2499-19.</p>		
SUSAN WALKER VS BAYER CORPORATION SETTLEMENT PAYMENTS	<p>A cash settlement as a result of a class action lawsuit.</p> <p>Unearned</p>	E	E
TAX REFUNDS	<p>A refund of taxes paid on food, income or property. It may be considered as earned or unearned.</p> <p>Earned</p> <p>A refund of federal or state taxes paid on income.</p> <p>Unearned</p> <p>A refund of taxes paid on food or property, such as real property or automobiles.</p> <p>Refer to Section 2405, Treatment of Income.</p> <p>* Refer to Section 2552, PL/CS Deductions.</p>	E	*
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	<p>Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments.</p> <p>TANF benefits received from another state are budgeted for the month of receipt only.</p> <p>*For ABD Medicaid, do not deem TANF income of the A/R's parent or spouse to the A/R.</p>	ABD – I* FM - E	I
TIPS	Earned – Voluntary payments above	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	the stated cost of a product or service given in appreciation for the service rendered. Refer to Wages in this chart.		
TRADE READJUSTMENT ALLOWANCE (TRA)	UNEARNED-Weekly payment available for up to 52 weeks after an individual's UCB is exhausted and during a period in which the individual is participating in a full-time training program approved in accordance with the Trade Act.	I	I
TRAINING ALLOWANCES/STIPENDS (Refer to WIA for treatment of WIA income)	Earned – Payments received from vocational/ rehabilitation programs recognized by Federal, State, local governments to the extent they are not a reimbursement or specifically excluded. NOTE: If the earnings belong to a child, refer to Child's Earnings in this chart.	I	I
TRANSITIONAL SUPPORT SERVICES (TANF)	UNEARNED- TANF support payment used to pay for or reimburse the cost of childcare, transportation, and incidental expenses to an applicant or recipient. TSS is available for a period of six months beginning with the first month of TANF ineligibility. *For ABD Medicaid, do not deem WSP income of the A/R's parent or spouse to the A/R.	ABD-I* FM-E	I
TRUST FUND PROCEEDS	Unearned – Money in a trust fund. * If the trust is not a Medicaid Qualifying Trust (MQT), include as income only those trust proceeds actually provided to the A/R by the trustee.	*I	*I
TRUST FUND PROCEEDS (cont'd)	* If the trust is an MQT, refer to Section 2336 , Trust, Medicaid Qualifying, for information on how to treat the trust proceeds. Verify by a copy of the trust document	*I	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	and contact with the trustee.		
UNEMPLOYMENT COMPENSATION BENEFITS (UCB)	Unearned – Benefits received from the Department of Labor (DOL) by unemployed individuals. Usually received weekly. Continue to count until notified by the A/R of termination. Use DOL Clearinghouse for verification of the amount and date of weekly benefits.	I	I
UNION FUNDS	Unearned – Refer to Strike Benefits in this chart.	I	I
UNIVERSITY YEAR FOR ACTION (UYA)	Unearned – payments received under a federal volunteer services program.	E	I
UTILITY PAYMENT (HUD SECTION 8/GRFA/FMHA)	Unearned - *Refer to Housing and Development (HUD) in this chart.	*	*
VACATION PAY	Earned – Any amount paid to employees for a regular scheduled period spent away from work or regular duty. It includes amounts paid even if the employee chooses not to take a vacation. Refer to Wages in this chart.	I	I
VENDOR PAYMENT	UNEARNED-Money paid by an outside source to a third party on behalf of the AU for an expense.	E	E
	Personal expenses paid for by another person that does not make up for a loss caused by that person.	I	
	Personal expenses paid for by another person that makes up for a loss caused by that person, and only restores the individual to a position before the loss.	E	
VENDOR PAYMENT (cont'd)	Housing assistance payments made by a state or local government to a third party on behalf of an AU residing in transitional for the homeless.	E	

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	NOTE: If the vendor payment is made with GA funds, refer to General Assistance Vendor Payments in this chart. NOTE: For ABD Medicaid, consider possibility of ISM. Refer to Section 2430 .		
VETERANS ADMINISTRATION (VA) BENEFITS	Refer to Section 2418 – VA Income for a description of the different types of VA income.		
VA PENSION	Unearned VA pensions are IBON and are not entitled to the \$20 general exclusion. (Section 2505)	ABD-I FM-E	I
VA COMPENSATION	Unearned VA compensation is not IBON. EXCEPTION: Compensation received by parents due to the service connected death of their child is IBON.	ABD-I FM-E	I
VA EDUCATIONAL BENEFITS	Unearned	ABD – I FM – E	E
Other VA Benefits Which are NOT Included As Income in the Eligibility Determination	Aid and Attendance Unusual Medical Expense (UME) reimbursement & Continuing Medical Expense (CME) Housebound Allowance Clothing Allowance	E E E E	E E E E
Augmented VA Benefits	Unearned *Refer to Section 2418 , VA Income for specifics on counting Augmented VA income. NOTE: Any portion of a VA check augmented for dependents is income to	ABD-*I FM-E	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	the dependent(s).		
Augmented VA Benefits To NH/CCSP A/Rs	<p>Unearned</p> <p>* Refer to Section 2418, VA Income for specifics on counting Augmented VA income for LA-D A/Rs.</p> <p>NOTE: Augmented VA benefits are treated differently than augmented RR benefits. The entire amount of an augmented RR check is income to the beneficiary.</p>	ABD-*I FM-E	*I
VA Recoupment	Repayment of VA benefits which are deducted from the VA check.	I Count the gross amount for eligibility determination FM-E	E Count the gross less recoup-ment
VA Lump Sum	<p>Unearned</p> <ul style="list-style-type: none"> Any portion of a VA lump sum that is not VA Aid and Attendance, is not VA UME reimbursement or is not augmented is counted as unearned income for the month of receipt. 	ABD-*I FM-E	*I
VICTIM RESTITUTION	<p>Unearned – Money received by a victim of a crime from a crime victim restitution program, usually a reimbursement for financial losses.</p> <ul style="list-style-type: none"> The value of the payment does not exceed the value of the loss The value of the payment exceeds the value of the loss. Count the excess value as income in the month of receipt. 	E E I	E E I
VICTIM RESTITUTION (cont'd)			

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	<ul style="list-style-type: none"> The payment is a set monthly amount based on a court ruling. Count as income in the month of receipt. 	I	I
VISTA VOLUNTEER PAYMENT	Earned – Income received by VISTA volunteers under Title I of the Domestic Volunteer Services Act. Included are payments from the Urban Crime Prevention Program	E	E
VOLUNTEER PAYMENT RSVP Foster Grandparent/ VISTA Urban Crime Prevention	<p>Unearned – Title II of Domestic Volunteer Services Act of 1973</p> <p>Unearned – Payments from Title I. Exclude only if the A/R was receiving FS or AFDC at the time they joined Title I even if there is a break in participation.</p>	E E	I I
WAGES (SALARIES) Children in Placement	<p>Earned – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis.</p> <p>Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee's share of FICA when paid by the employer. Reference Section 2835, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria.</p>	I	I
WORKER'S COMPENSATION	<p>Unearned – payments awarded to injured employees or to their survivors. Exclude any portion designated for medical, legal, or related expenses paid or deducted and not controlled by the A/R in connection with claim.</p> <p>Verify from the employer or from the source of the payment.</p>	ABD-I FM-E	I
WORKFORCE INVESTMENT ACT	Earned – Income received while working as part of a WIA program.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
WORK STUDY PROGRAM (Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	E	N/A
WORK STUDY PROGRAM (Non-Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	I	N/A
WORK SUPPORT PAYMENTS (WSP)	A time limited cash supplement to a TANF assistance unit that, because of employment, either becomes ineligible for TANF or experiences a reduction in its TANF benefit amount and declines ongoing TANF in order to stop the TANF clock. *For ABD Medicaid, do not deem WSP income of the A/R's parent or spouse to the A/R.	ABD-I* FM-E	I
YOUTH BUILD PROGRAM PAYMENTS	EARNED- Payments made through the Youth Build Program. *See WIA for treatment of this income.	I*	I*
YOUTH PROJECT PAYMENTS	Unearned – Payments made through projects developed to assist youth in acquiring work skills including the following: <ul style="list-style-type: none"> Youth incentive entitlement pilot project Youth community conservations and improvement projects Youth employment *See WIA for treatment of this income.	I*	I*



MEMORANDUM

To: Dr. Rony Francois, Director
Office of State Operations, Division of Public Health

From: Yvonne Greene, Eligibility Program Director 2
Medicaid Eligibility Policy (DCH)

Date: November 15, 2010

Subject: Public Health's Presumptive Eligibility on GAMMIS

On November 1, 2010 the Department of Community Health transitioned to a new Medicaid information system. Hewlett Packard Enterprise Services (HP) replaced Affiliated Computer Systems (ACS) as the fiscal agent for the Medicaid Management Information System (MMIS).

The new HP MMIS will be known as the Georgia Medicaid Management Information System or GAMMIS. This memorandum is to provide the Division of Public Health (PH) with new HP contact information for Presumptive Eligibility (PE) Pregnancy Medicaid and Women's Health Medicaid.

Member Identification Cards

All Georgia Medicaid members will receive new member ID cards. The Medicaid card will have information which coincides with the new GAMMIS contract with HP Enterprise Services. The new cards will be distributed via mass mailing by the end of October 2010.

Members that were already known to the system will continue eligibility with the previously assigned 111 Medicaid ID number; however, members approved for the first time on or after 11/1/10 will receive a Medicaid ID number beginning with 222.

Member/Provider Contact Center

The **HP Member Contact Center** will be available via phone Monday through Friday (excluding state holidays) from 7 am to 7pm at 770-325-2331 local or toll free outside metro area at 1-866-211-0950.

The **HP Provider Contact Center** will be available via phone Monday through Friday (excluding state holidays) from 7 am to 7pm at 770-325-9600 local or toll free outside metro area at 1-800-766-4456.

Members/Providers can access eligibility information via GAMMIS web portal at www.mmis.georgia.gov or the Interactive Voice Response System (IVRS) at 770-111-4456 (Providers) and at 1-866-211-0950 (Members).

The Presumptive Eligibility (PE) Corrections email box will be deactivated effective November 30, 2010 as all documents requiring updates must be scanned and completed by HP. PH will call the Provider Contact Center for any GAMMIS updates needed or fax form 632 or 632W for updates to HP at **1-866-483-1044**.

Presumptive Eligibility Manual

The PE manual was not updated by ACS for 10/10; however, it is currently located at: <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Presumptive%20Eligibility.pdf>. A few updates will be completed in the near future to correctly update the manual with HP and GAMMIS information only; there are no changes in policy.

Forms

Requests for DMA forms can be submitted using the Contact Us feature located in GAMMIS web portal or by contacting the HP mailroom supervisor, Milton Giles, at 770-492-5387.

Please distribute to all State Office Staff, supervisors and members of the PH team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Gloria D. Hill at 404-463-0521.

cc: Jon Anderson, Deputy Chief, Member Services & Policy
Isabel Blanco, DHS/DFCS Executive Director
Kathy Herren, DHS/DFCS Deputy Director Programs & Policy
Lynne Boring, Operations Director, DHS Office of Family Independence
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, Director, DHS Right from the Start Medicaid
Mandy Corlee, Project Manager, DHS Right from the Start Medicaid
Sophia Jefferies, Program Consultant, Division of Public Health
Cathy Broom, Program Consultant, Division of Public Health
Lynnette Rhodes, DCH Legal Services



MEMORANDUM

TO: Dr. Rony Francois, Director
Office of State Operations, Division of Public Health

FROM: Yvonne Greene, Eligibility Program Director 2 
DCH Medicaid Eligibility & Policy

DATE: December 7, 2010

SUBJECT: Planning for Healthy Babies (P4HB) – Family Planning Waiver

The Planning for Healthy Babies (P4HB) waiver covers Family Planning services to women ages 18 through 44 who are at or below 200 percent of the federal poverty level (FPL), who are not covered by insurance including Medicare and not otherwise receiving benefits under another Medicaid program. P4HB covers Inter-Pregnancy Care (IPC) services, including primary care case management, for eligible women who have delivered a very low birth weight baby (VLBW). Women, actively receiving Medicaid, that have delivered a very low birth weight baby, may receive services in the Resource Mother component of P4HB. P4HB is a five-year term demonstration waiver scheduled to begin January 1, 2011 and end in December 31, 2015.

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

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

Family Planning Services

P4HB extends eligibility for Family Planning services to women aged 18 through 44 years who are at or below 200 % of the most current FPL. All women are potentially eligible to meet the program requirements for Family Planning services.

Family Planning services include medically necessary services and supplies related to birth control and pregnancy prevention. Services include contraceptive management with a variety of methods, patient education, counseling, and referral as needed to other social services and health care providers

Women approved for P4HB will receive Family Planning services such as:

- Family planning exams
- Birth control services and supplies including tubal ligations
- Health education and counseling
- Follow up visits with your family planning doctor or nurse
- Counseling and referrals to community agencies and health care providers
- Family planning lab tests such as pregnancy tests and pap smears
- Screening, treatment and follow up for STDs (except HIV/AIDS and Hepatitis) discovered during your family planning exam
- Vitamin B9 (which is Folic Acid) supplements
- A Tetanus, Whooping Cough, and Diphtheria booster if you are age 20 or younger and are due for a booster
- Hepatitis B vaccine if you are age 20 or younger and have not received this vaccine before

Women enrolled in Family Planning services will have access to the family planning providers only, and must enroll in a care management organization (CMO) prior to obtaining services.

All pregnant women members receiving any Medicaid Class of Assistance (COA) will receive a letter in their eighth month of pregnancy informing them of the P4HB program, along with a P4HB application. The Department of Community Health's goal is for all Medicaid COA cases terminating will have a Continued Medicaid Eligibility (CMD) process completed; specifically the Right From the Start (RSM) Pregnant Women would have a seamless transition into the P4HB program after their 60 day transitional Medicaid ends, if they are ineligible for any Medicaid program. RSM Pregnant Women approved for P4HB may continue to use their same CMO of either WellCare, Peach State or Amerigroup. P4HB women may contact the CMO for additional information.

WellCare: georgia.wellcare.com or
call 1-866-231-1821 (TDD/TTY 1-877-247-6272)

Peach State: www.pshp.com or
call 1-866-704-1484 (TDD/TTY 1-800-659-7487)

Amerigroup: www.myamerigroup.com or
call 1-800-600-4441 (TDD/TTY 1-800-855-2880)

P4HB women have the right to change their CMO within the first 30 days of approval. If the member selects a new CMO by the 23rd of the current month, the change will be effective the 1st of the following month.

Inter-Pregnancy Care Services

The P4HB program includes an Inter-Pregnancy Care (IPC) component for women aged 18 through 44 years at or below 200% of the most current FPL who have delivered a VLBW baby as of January 1, 2011.

Women enrolled in the IPC program will have access to the CMO's family planning and primary care providers, some dental services and Resource Mother services. This expanded eligibility will: increase access to Family Planning services by permitting women to use private health care providers as well as county public health departments and community health centers; and reinforce the medical home concept by allowing women to choose their delivering physician or prenatal care provider as their family planning provider.

Resource Mother Services

The P4HB program includes a Resource Mother component for women aged 18 through 44 years at or below 200% for the most current FPL. These women will be actively receiving Medicaid or PeachCare for Kids™ and have delivered a VLBW baby on or after January 1, 2011.

The Resource Mother services will assist these members with:

- Primary Care medical appointments
- Arrange non-emergency medical transportation
- Healthy eating choices and smoking cessation
- Medications to treat chronic health conditions
- Coordination of social services support
- Obtaining regular preventive health visits
- Obtaining immunizations for your child or children
- Finding local resources in your community

PSI will mail the Resource Mother letter to all pregnant women members receiving Medicaid. The Resource Mother component enhances the member's Medicaid or PeachCare for Kids™ coverage and a P4HB application is not required.

P4HB Program Requirements:

- Available to women aged 18 through 44 years who are at or below 200 % of the most current FPL. The current FPL will be based on family size. Eligibility may begin the month that the 18th birth date falls and will end the last day of the month that the 45th birth date falls.

- There is no resource test.
- Are U.S. citizens or qualified Immigrants.
- Must be a Georgia Resident.
- There is no three months prior coverage.
- Standard income deductions apply:
 - \$90 earned income
 - \$50 child support
 - \$200 under age 2 dependent care
 - \$175 over age 2 dependent care
- Eligibility for P4HB IPC services is limited to (24) twenty-four consecutive months. A woman is no longer eligible for P4HB if she reaches the age limit or is no longer able to become pregnant as a result of sterilization, surgical procedure, etc. If this is the case she cannot reenroll in P4HB. If a woman becomes pregnant while enrolled in P4HB, after verification of pregnancy, she may be transitioned into RSM Pregnancy Medicaid as the Continuing Medicaid Determination (CMD) eligibility process. A former pregnant woman may reenroll in P4HB after delivery of her child if she is not eligible for another Medicaid program.
- All pregnant women approved for Presumptive Eligibility (PE) Medicaid should be given P4HB information along with the Women, Infants and Children (WIC) program information.
- Required to report changes within (10) ten days.
- P4HB is subject to an annual review.

P4HB Application and Process

The P4HB PDF application form, poster and resource material are attached and can be printed locally or the Division of Public Health (PH) can email Ms. Duncan at cduncan@dch.state.ga.us to obtain applications, posters and resource material by mail. Each PH office should maintain a supply of applications and resource material on hand at all times. At minimum, all PH lobbies should contain the P4HB poster clearly displayed for the general public.

All applications will be mailed or faxed to Policy Studies, Inc. (PSI) at:

P4HB
P.O. Box 1810
Atlanta, GA 30301-1801

Fax: 1-888-744-2102

Applicants may access an on-line application at www.planning4healthybabies.org.

All changes reported by the applicant or member; any questions regarding P4HB; and all applications and reviews will be completed by PSI. Applicants and members can call toll free 1-877-P4H-B101 (744-2101).

P4HB allows 18 year old females to be in their own case even if they live with their mother as long as she is also active in the P4HB program. Budget groups will be calculated as they currently are which will include the spouse, and their mutual child(ren), (biological or adoptive).

P4HB Aid Categories and New CMO Card

Family Planning- 181; will receive a pink CMO card
Inter-Pregnancy Care- 180; will receive a purple CMO card
Resource Mother Family Medicaid- 182; will receive a yellow CMO card
Resource Mother ABD/SSI Medicaid- 183; will receive a yellow CMO card

Please distribute to all State Office Staff, supervisors and members of the PH team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson at 404-463-0521.

Attachments

cc: Jon Anderson, Deputy Chief, Member Services & Policy
Isabel Blanco, DHS/DFCS Executive Director
Kathy Herren, DHS/DFCS Deputy Director Programs & Policy
Lynne Boring, Operations Director, DHS Office of Family Independence
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, Director, DHS Right from the Start Medicaid
Mandy Corlee, Project Manager, DHS Right from the Start Medicaid
Lynn Campbell, DCH Family Planning Program Manager
Kaprice S. Welch, DCH Women's Service Director
Sophia Jefferies, Program Consultant, Division of Public Health
Cathy Broom, Program Consultant, Division of Public Health
Lynnette Rhodes, DCH Legal Services



MEMORANDUM

To: Dr. Seema Csukas, Interim Program Director
Maternal and Child Health and WIC Programs
Department of Public Health

From: Yvonne Greene, Eligibility Program Director 2
Medicaid Eligibility Policy (DCH)

Date: March 9, 2012

Subject: Updated Presumptive Eligibility (PE) Changes/Corrections Procedures

The PE Pregnancy manual scheduled for update April 1, 2012 will reflect these changes. These procedures apply to PE Pregnancy Medicaid and PE Women’s Health Medicaid.

CURRENT PROCEDURES

Qualified Providers (QPs)/Department of Public Health (DPH) cannot make any changes to an eligible active PE case using the Georgia Medicaid Management Information System (GAMMIS) web portal. Any changes that need to be updated are emailed to pecorrections@dch.ga.gov. Corrections are completed Monday-Friday, 8:00 AM – 5:00 PM.

DCH has not finalized the system fix for PE cases to be entered when a member has an active Planning for Healthy Babies (P4HB) case. The QP/DPH has to fax the 632 or 632W form to Memi Wilson to have the PE manually updated and P4HB closed.

NEW PROCEDURES

Effective immediately, but no later than 4/1/12, QP/DPH will fax required PE correction requests directly to the DCH fiscal agent, HP, using the attached coversheet. Required changes include:

- Name
- Address
- Residential County Code
- Social Security Number
- Date of Birth
- Duplicate ID Merge
- Application Date



Dr. Seema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 2

Additional corrections that can be made with any of the required changes listed above include:

- Administrative County Code
- Race
- Ethnicity
- Citizenship
- Expected Birth Date of Fetus
- Number of Births

COVERSHEET

The attached coversheet should be copied and pasted on to your office letterhead. This is the only alteration allowed to this coversheet. This coversheet should only be used to report required corrections to PE cases. The form 632 or 632W must be faxed with this coversheet as page two (2); no additional pages should be attached to the fax for PE corrections.

If the 632 or 632W is not attached, HP will not make the change.

If HP cannot read the 632 or 632W they will attempt one time to contact the person who faxed the request. If no contact is made by QP/DPH, the PE change will not be completed.

The coversheet contains four (4) sections.

1. Identify PE

<u>PRESUMPTIVE ELIGIBILITY CHANGES/CORRECTIONS</u>			
FAX TO: HP Member Enrollment	TODAY'S DATE: _____		
1-866-483-1045			
UPDATE (check one):	<input type="checkbox"/>	PE PREGNANCY Attach Form 632	<input type="checkbox"/>
		PE WHM Attach Form 632W	

Add today's date and check which PE program will be corrected. The HP fax number should be used by QP/DPH and the Division of Family and Children Services (DFCS) offices only.

Only one complete fax is needed. Change requests faxed to HP, Monday-Friday, 8:00 AM – 4:45 PM will be completed in three (3) business days.

QP/DPH can access GAMMIS on the Web portal to determine that the change was completed; there will be no notification of the completion.



Dr. Seema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 3

2. Required Changes/Corrections Needed

Name <input type="checkbox"/>
Address <input type="checkbox"/>
Residential County Code <input type="checkbox"/>
Social Security Number <input type="checkbox"/>
Date of Birth <input type="checkbox"/>
Duplicate ID Merge: _____ Original _____ Duplicate
Application Date (only if the application date is in another month) <input type="checkbox"/>

Check the appropriate box(es) on the change(s)/correction(s) as needed. Each of these changes can be found on the attached 632 or 632W form except for duplicate ID numbers.

The following required changes/corrections are needed so the member can receive correct PE services by providers:

Name –member cannot receive prescriptions when the name is spelled wrong and/or the first and last name are reversed.

Address –the Care Management Organizations (CMOs) begin to mail their welcome aboard packets to members using this address. The member has a limited amount of time to choose their CMO, otherwise a CMO will be chosen for them.

Residential County-the Non Emergency Transportation (NET) uses this code to provide services.

Social Security Number- used to match with other systems. If the member needs assistance and does not have their member ID number this is one way the providers/HP/DCH can identify the member.

Date of Birth- if the member needs assistance and does not have their member ID number this is one way the provider/HP/DCH can identify the member.



Dr. Seema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 4

3. Additional changes

Administrative County Code

Race: American Indian or Alaskan Asian Black Caucasian
 Hispanic Other: _____ (specify)

Ethnicity: Hispanic N/A

Citizenship: U.S. Citizen Qualified Immigrant Illegal Immigrant
 Other: _____ (specify)

Expected Birth Date of Fetus

Number of Births

If “additional changes” are the only changes requested do not fax the form to HP. These changes will be updated in GAMMIS when the full Medicaid determination is completed. HP will not make any “additional changes” if there is not a required change/correction.

4. Contact Information

CONTACT INFORMATION:
Name of person completing this form: _____
Please Print Clearly
Direct phone number of person completing this form: _____

The person submitting the form to HP will need to provide a name and direct phone number in this section. This may not necessarily be the person that completed the 632 or 632W form. This section is used if HP or DCH needs to contact this individual to obtain information to update the PE; please print clearly.

PE CORRECTIONS EMAIL BOX

This email box will now be used to report PE cases that cannot be updated due to a system error message given to QP/DPH on the PE Panel screen. All PE should be added to GAMMIS using the web portal. You will not be able to add a PE to the web portal when the member is active for P4HB.



Dr. Seema Csukas, Interim Program Director
PE change(s)/correction(s) Procedures
Page 5

QP/DPH may not see the active P4HB when screening on the web portal because the member is not enrolled in a Managed Care Healthy Baby (MCHB) plan. MCHB may be either WellCare, Amerigroup, or Peach State. Until the system fix is completed, you will not be able to add PE on the web portal for an active P4HB member.

If the QP/DPH has the ability to scan the 632 or 632W form they can email the form to pecorrections@dch.ga.gov; or fax the 632 or 632W form only to 1-770-302-8169. After 4/1/12 any documents faxed to the PE Corrections email box other than the 632 or 632W forms will not be acted upon.

Please distribute to all State Office Staff, supervisors and members of the QP team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson, Family Medicaid Program Consultant, at 404-463-0521.

cc: Jon Anderson, DCH Deputy Chief, Member Services & Policy
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, DHS/DFCS Director Right from the Start Medicaid
Sophia Jefferies, Program Consultant, Department of Public Health
Cathy Broom, Program Consultant, Department of Public Health
Lynnette Rhodes, DCH Legal Services
HP File



David A. Cook, Commissioner

Nathan Deal, Governor

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

MEMORANDUM

TO: Dr. Seema Csukas, Interim Program Director
Maternal and Child Health and WIC Programs
Department of Public Health

FROM: Yvonne Greene, Eligibility Program Director 2
Medicaid Eligibility Policy (DCH)

DATE: January 31, 2013

SUBJECT: Increase in Income Levels for Presumptive Eligibility (PE) Medicaid

The poverty level income limits used to determine Presumptive Eligibility Medicaid have changed. Income limits are based on the federal poverty guidelines that are revised and published annually. These new income limits should be used for all Presumptive Eligibility determinations completed by the Department of Public Health, beginning February 1, 2013.

<u>Family Size</u>	<u>Federal Poverty Guidelines</u>	<u>Monthly Income Limit</u>
1		\$ 1916
2		\$ 2586
3		\$ 3256
4		\$ 3926
5		\$ 4596
6		\$ 5266
7		\$ 5936
8		\$ 6606

EACH ADDITIONAL PERSON ADD: \$670

Please distribute to all State Office Staff, supervisors and members of the DPH team that process the PE Pregnancy Medicaid and/or the PE Women's Health Medicaid. If you have questions or need additional information please contact Memi Wilson, mwilson@dch.ga.gov, at 404-463-0521.

- cc: Jon Anderson, Deputy Chief, Member Services & Policy
- Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
- Gwendora Bailey, Director, DHS Right from the Start Medicaid
- Sophia Jefferies, Program Consultant, Division of Public Health
- Cathy Broom, Program Consultant, Division of Public Health
- Lynnette Rhodes, DCH Legal Services
- Federally Qualified Health Centers/Rural Health Centers



February 20, 2015

MEMORANDUM

TO: Dr. Seema Csukas, Director Maternal and Child Health Section, Department of Public Health
FROM: Yvonne Greene, Eligibility Program Director 2 DCH Medicaid Eligibility & Policy
RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2015

The purpose of this memorandum is to inform Qualified Providers (QP) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2015. The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2015 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in processing presumptive eligibility effective April 1, 2015.

PE Pregnant Women Medicaid FPL at 220% effective April 1, 2015

Table with 4 columns: Budget, 220% FPL, 5% Deduction, 220% Plus 5%. Rows 1-12 showing values for different budget groups.

Add \$763 to the net income limit, and \$17 to the deduction, for any additional individual(s) added

Page 2
February 20, 2015
Dr. Seema Csukas

Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level. Please use this income limit chart effective April 1, 2015.

Budget Group	200% FPL
1	1962
2	2655
3	3349
4	4042
5	4735
6	5429
7	6122
8	6815
9	7509
10	8202
11	8895
12	9589

Add \$694 to the net income limit for any additional individual(s) added.

Please distribute to all State Office Staff, Supervisors, and members of the QP team that process the PE Pregnant Women Medicaid and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact Karen Y. Houston, Family Medicaid Program Consultant, at 404-657-7270.

cc: Bonnie Taylor, Interim Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director, Medicaid Legal Services
Randall Solomon, Interim Member Enrollment Director
Wesley Merritt, QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



March 4, 2015

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

FROM: Yvonne Greene, Eligibility Program Director 2 *YGS*
Medicaid Eligibility Policy (DCH)

RE: GAMMIS system changes for Presumptive Pregnant Women and Presumptive Women's Health Medicaid

The purpose of this Memorandum is to inform Qualified Providers of the system changes within GAMMIS in reference to the begin date of eligibility for persons who are determined presumptively eligible and changes to the panels implemented on 02/26/15.

Presumptive Eligibility (PE) Start Date

Members determined Presumptively Eligible will have an eligibility start date based on the date the Qualified Provider determines the member eligible for Presumptive Eligibility. The member's eligibility will no longer revert to the first day of the month.

Women's Health Medicaid Panel Changes

- Women's Healthcare Request panel has been changed to Women's Health Medicaid Panel
- Determination/Eligibility Begin date field- This field will replace the Eligibility Begin Date field. The date in this field will represent member's effective date of eligibility. The system will default to the current date. The member's eligibility will no longer revert to the first day of the month.
- Net income –The members calculated net income
- Application date- This is the date the member applied for PE services. This date cannot be more than 30 calendar days in the past or future.
- Medicaid Application submitted Y/N- Select Y or N if the member completed a full Medicaid application.

Pregnant Women Panel Changes:

- Determination/Eligibility Begin date field- This field will replace the Eligibility Begin Date field. The date in this field will represent the member's effective date of eligibility. The system will default to the current date. The member's eligibility will no longer revert to the first day of the month. Application Date- This is the date the member applied for PE services. This date cannot be more than 30 calendar days in the past or future.
- Net taxable income -The member's net taxable income.
- Medicaid Application Submitted Y/N- Select Y or N if the member completed a full Medicaid application.
- Presumptive Pregnant Women will now have the aid category of 864. Aid category 865 will no longer be available; however the member will be eligible to receive the same level of coverage and services.

Please distribute to all State office staff, supervisors, and members of the QP team that process the PE Pregnant Women Medicaid and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact Anika Washington, awashington1@dch.ga.gov, Program Consultant at 404-657-7263.

cc: Jonathan Duttweiler, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Ginger Henry, Interim Medicaid Policy Unit Manager, DFCS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director
Shelia Alexander, PeachCare for Kids® Program Director
Barbara E. Crane, Director, Office of Cancer Screening and Treatment, DPH
Cathy Broom, Program Consultant, DPH
Paula Brown, Project Officer, DPH
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

July 9, 2015

MEMORANDUM

TO: Ginger Henry, Medicaid Policy Unit Manager
DFCS Office of Family Independence

FROM: Yvonne Greene, Eligibility Program Director 2 *YJG*
DCH Medicaid Eligibility & Policy

RE: Same Sex Marriage - How do we treat Income and Resources?

Question:

If we have a same sex married couple, how do we treat income and resources, both if they indicate they file jointly or indicate they file separately. How do we determine who gets included in a Parent/Caretaker with children budget, if income eligible?

Response:

On June 26, 2015, the Supreme Court, in *United States v. Obergefell ET AL. v. Hodges, Director, Ohio Department of Health, ET AL.* held: "The Fourteenth Amendment requires a State to license a marriage between two people of the same sex and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out of state." In addition "The Court, in this decision, holds same-sex couples may exercise the fundamental right to marry in all States. It follows that the Court also must hold – and it now does hold – that there is no lawful basis for a State to refuse to recognize a lawful same-sex marriage performed in another State on the ground of its same-sex character." Governor Deal states Georgia will abide by the Federal law. As of June 26, 2015 Georgia recognizes same sex marriage for the Medicaid and PeachCare for Kids® programs.

For Medicaid Modified Adjusted Gross Income (MAGI), Non-MAGI and PeachCare for Kids® programs the treatment of income and resources will be the same for same sex married couples and married couples of the opposite sex.

Please note we do not count resources in MAGI.

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

Equal Opportunity Employer

Ginger Henry
Page 2
July 9, 2015

Please update the Office of Family Independence Medicaid procedures manual to reflect this change throughout. Also, issue a numbered bulletin to expedite the dissemination of this information. If you have any questions or need additional information please contact Karen Y. Houston at 404-657-7270.

cc: Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director of Medicaid Legal Services
Wesley Merritt, QC Program Director 2
Randall Solomon, Interim Member Enrollment Director
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

MEMORANDUM

TO: Carrie Summers, VP, Healthcare Financing
Georgia Hospital Association

FROM: Yvonne Greene, Eligibility Program Director 2 *YJG*
DCH Medicaid Eligibility & Policy

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2016

DATE: March 11, 2016

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2016. The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2016 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in processing presumptive eligibility effective April 1, 2016.

Budget Group	Parent/Caretaker with Children		Children 6-18			Children 1-5			Children 0-1		Pregnant Women		PCA		P466
	Limit	5%	Under Age 19	133%	Plus 5%	180%	Plus 5%	205%	Plus 5%	220%	Plus 5%	247%	Plus 5%	200%	
1	310	50	360	1317	1367	1476	1526	2030	2080	2178	2228	2446	2496	1980	2030
2	457	67	524	1776	1843	1990	2057	2737	2804	2937	3004	3298	3365	2670	2737
3	551	84	635	2235	2319	2504	2588	3444	3528	3696	3780	4150	4234	3360	3444
4	653	102	755	2694	2796	3018	3120	4152	4254	4455	4557	5002	5104	4050	4152
5	752	119	871	3153	3272	3532	3651	4859	4978	5214	5333	5854	5973	4740	4859
6	826	136	962	3611	3747	4046	4182	5506	5702	5973	6109	6707	6843	5430	5566
7	903	154	1057	4072	4226	4561	4715	6276	6430	6735	6889	7561	7715	6122	6276
8	970	171	1141	4533	4704	5078	5249	6987	7158	7498	7669	8418	8589	6816	6987
9	1034	188	1222	4995	5183	5595	5783	7698	7886	8262	8450	9275	9463	7510	7698
10	1113	206	1319	5455	5661	6111	6317	8408	8414	9023	9229	10,130	10,336	8202	8408
11	1194	223	1417	5916	6139	6628	6851	9119	9342	9786	10,009	10,987	11,193	8896	9119
12	1244	240	1484	6378	6618	7145	7385	9830	10,070	10,550	10,790	11,844	12,084	9590	9830

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

Equal Opportunity Employer

Carrie Summers
Page 2
March 11, 2016

Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level. Please use this income limit chart effective April 1, 2016.

Budget Group	200% FPL
1	1980
2	2670
3	3360
4	4050
5	4740
6	5430
7	6122
8	6816
9	7510
10	8202
11	8896
12	9590

Add \$694 to the net income limit for any additional individual(s) added.

Please distribute to all Hospital Staff, Supervisors, and members of the QH team that process the PE Pregnant Women Medicaid, PE Parent/Caretaker with Children Medicaid, Children under 19 Medicaid, and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact, Gloria D. Hill, Healthcare Program Consultant 3, at 404-463-0521, cell 470-259-8609 or ghill1@dch.ga.gov.

cc: Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Medical Assistance Group Director
Tara Dickerson, Deputy General Counsel
Randall Solomon, Member Enrollment Director
Wesley Merritt, QC Program Director 2
Sheila Alexander PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



August 21, 2014

MEMORANDUM

TO: Jonathan Duttweiler, Medicaid Policy Unit Manager
DFCS Office of Family Independence

FROM: Yvonne Greene, Eligibility Program Director 2 
DCH Medicaid Eligibility & Policy

RE: Social Security Retirement, Survivor's, Disability Insurance (RSDI) Income of Tax Dependents for Modified Adjusted Gross Income (MAGI) based Medicaid and PeachCare for Kids® determinations.

BACKGROUND

The Patient Protection and Affordable Care Act of 2010 required the use of new financial methodologies when determining Medicaid eligibility for MAGI classes of assistance. This methodology redefines the financial household by utilizing the tax filing status of an applicant or beneficiary. The household composition rules are applied to classes of assistance that are required to use MAGI methodology to determine household taxable income and eligibility

PURPOSE

To provide additional clarification on Social Security RSDI received by a tax dependent child for MAGI based budgeting based on the Affordable Care Act (ACA) effective January 1, 2014.

If the tax dependent/child has no other source of income and resides with a parent (biological, step, adopted), the Social Security RSDI income is excluded. RSDI of a tax dependent/child is countable only if the tax dependent/child has OTHER income that meets the IRS tax filing threshold for tax dependents or if the child does not reside with a parent and is not claimed as a tax dependent by his or her parent.

Jonathan Duttweiler
Page 2
August 21, 2014

Note: The filing threshold is applied based on whether the individual should file a tax return. If the individual does not file, the threshold still applies.

The current (2013) IRS tax filing thresholds for tax dependents are:

- **\$6100 annually for EARNED income**
- **\$1000 annually for UNEARNED income**

Note: RSDI does NOT count toward the unearned threshold.

Note: The 2014 IRS tax filing thresholds will begin in January 2015.

Please update the Office of Family Independence Medicaid procedures manual to reflect this clarification. Also, issue a numbered bulletin to expedite the dissemination of this information. If you have any questions or need additional information please contact Karen Y. Houston at khouston@dch.ga.gov or 404-657-7270 or Mollie Elder at melder@dch.ga.gov or 404-463-8369.

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, DCH Legal Services, Director
Wesley Merritt, QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer

Appendix R -Resources

Medicaid Transportation:

Non-Emergency Transportation

Members enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid members to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid member and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Department of Community Health (DCH) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the HP Member Contact Center at 866-211-0950.**

Please give PE members a copy of the following page regarding NET.

Non-Emergency Transportation

Effective on and after July 1, 2012, the following Non-Emergency Transportation (NET) Brokers will coordinate transportation for Medicaid members who have no other way to get to medical care or services covered by Medicaid. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday – Friday) from 7 a.m. to 6 p.m. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly.

If you need NET services, you must contact the NET Broker servicing the county you live in to ask for non-emergency transportation. Please see the chart below to determine which broker services your county and call the broker’s telephone number for that region.

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

The Division of Medicaid monitors the quality of the services brokers provide. If you have questions or comments about a NET Broker, contact HP Enterprise Services Contact Center at 866-211-0950.

PowerLine:

The PowerLine is a statewide toll-free telephone number that provides healthcare referrals.

The PowerLine is managed by Healthy Mothers, Healthy Babies Coalition of Georgia. It was established in 1984 as a means of directing pregnant women to prenatal services.

PowerLine's mission was expanded in 1989 via a contract with the Georgia Department of Community Health to assist women and children in accessing Medicaid providers and public health programs.

Today, PowerLine provides healthcare referrals to any Medicaid, PeachCare for Kids™ and uninsured Georgian.

PowerLine can assist both English and Spanish speaking customers in gaining accesses services.

The PowerLine maintains a database of Georgia's Medicaid and PeachCare for Kids™ accepting providers. For those not eligible for Medicaid or PeachCare for Kids™, referrals are made to healthcare providers who offer low-cost or sliding scale fee services.

To access the PowerLine, call 1-800-822-2539 or, in the metro Atlanta area, 770-451-5501 from 8:00 AM to 6:00 PM, Monday through Friday.

More information may be obtained at the following web site:

<http://www.hmhbga.org/index.php>

You can order free material to hand out to applicants by going to:

http://www.hmhbga.org/index.php?option=com_netinvoice&action=orders&ask=order&cid=2&Itemid=88

Materials Order Form

Healthy Mothers, Healthy Babies Coalition of Georgia offers FREE materials on PowerLine. Please submit your order below:



P O W E R L I N E

**The Healthy Mothers, Healthy Babies PowerLine is
your source for statewide healthcare referrals and information.**

**Metro Atlanta 770-451-5501
Statewide 800-822-2539**

Monday through Friday

8:00AM-6:00PM

PowerLine is a fast way to find exactly the care you need.

**PowerLine is a free service, funded by the Division of Public Health of the
Georgia Department of Community Health.**

One simple call puts you in contact with:

- ◆ Medicaid Doctors
- ◆ Dental Referrals
- ◆ Low-Cost Health Resources for the Uninsured
- ◆ WIC, Children 1st and Babies Born Healthy
- ◆ Low-Cost Prenatal Referrals
- ◆ Other Public Health Programs
- ◆ Referrals for Breastfeeding Questions
- ◆ Referrals to HIV Testing

PowerLine es una forma rápida de encontrar el cuidado que usted necesita. Una llamada le pone en contacto con:

- ◆ Referencias a Médicos
- ◆ Directorio de cuidado prenatal de bajo costo
- ◆ WIC, Children 1st, y sitios para pruebas de VIH
- ◆ Apoyo para Lactancia



Be Smart. Plan Before You Start!

Planning for Healthy Babies

What is the Planning for Healthy Babies program?

Planning for Healthy Babies provides no cost family planning services to eligible women in Georgia. You can enroll in either:

- Family planning
- Resource Mother – provides assistance to women who deliver a baby weighing less than 3 pounds 5 ounces
- Inter-pregnancy care (IPC) – only for women who deliver a baby weighing less than 3 pounds 5 ounces, and includes family planning and Resource Mother services

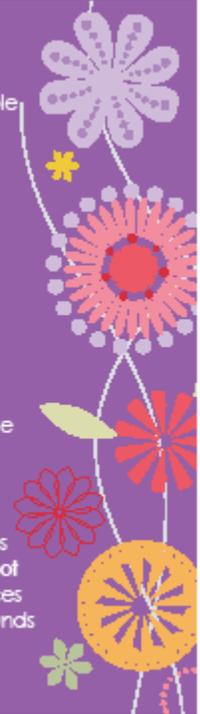
What's covered?

- Annual physical exams including pap smears
- Contraceptives and multivitamins with folic acid
- Family planning counseling
- IPC services including primary care and dental services, substance abuse treatment services, Resource Mother services and more

Who is eligible?

- Women ages 18 through 44 who meet monthly family income limits
- Women who do not receive Medicaid are eligible for family planning services
- Women who deliver a baby weighing less than 3 pounds 5 ounces and do not receive Medicaid or are losing Medicaid coverage, are eligible for IPC services
- Women who receive Medicaid and deliver a baby weighing less than 3 pounds 5 ounces are only eligible for Resource Mother services

See the other side to apply for Planning for Healthy Babies...



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Planning for Healthy Babies

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Planning for Healthy Babies

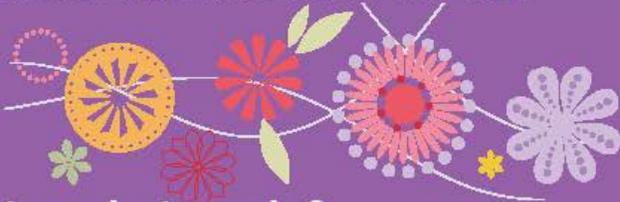


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For more information call **877-P4H-B101**.



How do I apply?

You can apply online at:

www.planning4healthybabies.org.

If you are unable to apply online, applications may be picked up at your local:

- Public health department
- Division of Family and Children Services (DFCS) office

Pick up a post card today!



Planning for
Healthy Babies





SECTION 3. Income/Dependent Care List all income received and all dependent care paid by household members.

INCOME:	AMOUNT BEFORE Taxes and Other Deductions	HOW OFTEN? (Weekly, Monthly, Every 2 weeks, Etc.)	NAME OF PERSON RECEIVING (Include only income of the children/parents at the address listed on the application)	DID YOU INCLUDE PROOF OF INCOME?
Current employer's name: _____				<input type="radio"/> Yes <input type="radio"/> No
Current employer's name: _____				<input type="radio"/> Yes <input type="radio"/> No
Social Security (RSDI)				<input type="radio"/> Yes <input type="radio"/> No
Supplemental Security Income				<input type="radio"/> Yes <input type="radio"/> No
Workers' Compensation				<input type="radio"/> Yes <input type="radio"/> No
Pensions or Retirement Benefits				<input type="radio"/> Yes <input type="radio"/> No
Child Support (List amount each child receives.)				<input type="radio"/> Yes <input type="radio"/> No
Self Employment				<input type="radio"/> Yes <input type="radio"/> No
Contributions				<input type="radio"/> Yes <input type="radio"/> No
Unemployment Benefits				<input type="radio"/> Yes <input type="radio"/> No
Other Income, please specify: _____				<input type="radio"/> Yes <input type="radio"/> No

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

NAME OF ADULT WHO WORKS	NAME OF CHILD OR ADULT CARED FOR	UNDER THE AGE OF 2 ?	NAME OF DAY CARE OR CAREGIVER	AMOUNT PAID	HOW OFTEN? <small>Weekly, BiWeekly, Monthly, Etc.</small>
		<input type="radio"/> Yes <input type="radio"/> No			
		<input type="radio"/> Yes <input type="radio"/> No			



SECTION 4. Proof of Income

You will be requested to provide the most recent copies of proof of all your income. You may provide verification with your application or you may choose to be notified by mail. These are the types of information you need to send for your application to be processed:

For money you earn by doing a job or service, you must send:

Weekly pay - (4) weeks of pay stubs (4 most current paystubs)—OR—Bi-Weekly pay - (2) pay stubs received every other week (2 most current paystubs)—OR—Semi-Monthly - (2) pay stubs received two times a month (2 most current paystubs)—OR—Monthly - (1) pay stub received one time a month (two most current paystubs)—OR—Paid Cash - Letter from Employer signed by an Officer of the Company on Company letterhead—OR—Yearly - Tax Forms filed—OR—Self Employment Documents - such as federal income tax return or business records including receipts, bills and invoices.

Please show proof of money anyone in the household receives from any agencies, parents or relatives, or any other sources. This might include: • SSI or SSA - Current year award letter • Unemployment check - (4) weeks of pay stubs (4 most current paystubs) • Workers' Compensation - letter from insurance company stating amount received and how often received, provide contact name and number. • Contributions - a signed/dated letter from person who gives you money, provide name, address and contact number. Provide amount received and how often received. • Child Support (paid directly to you) - a signed/dated written statement from the parent who gives you money, provide the name, address and contact number. Provide amount received and how often received. • Child Support (paid through court) - court papers or letter stating the amount of income received and how often it is received. • Other Unearned Income - a signed/dated letter stating amount received and how often received. Provide name, address and contact number or (4) weeks of pay stubs (4 most current paystubs).



SECTION 5. Understanding/Authorization Sworn Statement of Member.

I certify that I have provided true and accurate information about my family and income. I understand that my eligibility for on-going Planning for Healthy Babies services must be reviewed one year after approval. Proof of Citizenship or legal immigration status must be verified for eligibility for Planning for Healthy Babies. Failure to comply will result in a denial of your application. Social Security Numbers are used for computer matches with other agencies in order to assist in verifying eligibility for Planning for Healthy Babies.

I am applying for Planning for Healthy Babies or Medicaid for myself, I certify under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States.

APPLICANT'S SIGNATURE

DATE OF APPLICATION / /
MM/DD/YY

I, along with my other household members, wish to be considered for Medicaid for which we are potentially eligible.

I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits). I agree to cooperate with the State in identifying and providing information to assist the State in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within 10 business days of receipt.

I am a parent or legal guardian, I certify that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States.

PARENT OR LEGAL GUARDIAN'S SIGNATURE

DATE OF APPLICATION / /
MM/DD/YY

Georgia Department of Community Health
P4HB01 Rev 11/03/10

Please mail application and income documents to:

Planning for Healthy Babies (P4HB), P.O. Box 1810, Atlanta, GA 30301-1810 OR Fax to: 1-888-744-2102
If you have any questions, please call toll free: 1-877-P4H-B101 (744-2101)



SECCION 3. Ingresos/Cuidado de Dependiente Liste todos los ingresos recibidos y todos los cuidados de dependientes pagados por los miembros del hogar.

INGRESO:	CANTIDAD ANTES de impuestos y otras deducciones	¿QUÉ FRECUENCIA? (Semana, Mensual, cada 2 Semanas, Etc.)	NOMBRE DE LA PERSONA RECIBIENDO (Incluya el ingreso solo de los niños y padres en la dirección indicada en la solicitud)	¿INCLUYO PRUEBA DE INGRESOS?
Nombre del Empleador Actual:				<input type="radio"/> Si <input type="radio"/> No
Nombre del Empleador Actual:				<input type="radio"/> Si <input type="radio"/> No
Seguro Social (RSDI)				<input type="radio"/> Si <input type="radio"/> No
Seguro de Ingreso Suplementario				<input type="radio"/> Si <input type="radio"/> No
Compensación de Trabajadores				<input type="radio"/> Si <input type="radio"/> No
Pensiones o Beneficios de Jubilación				<input type="radio"/> Si <input type="radio"/> No
Sustento de Menores (Liste la cantidad que cada niño recibe.)				<input type="radio"/> Si <input type="radio"/> No
Empleo por Cuenta Propia				<input type="radio"/> Si <input type="radio"/> No
Contribuciones				<input type="radio"/> Si <input type="radio"/> No
Beneficio de Desempleo				<input type="radio"/> Si <input type="radio"/> No
Otros ingresos, por favor especifique:				<input type="radio"/> Si <input type="radio"/> No

¿Paga usted por cuidado de dependientes (o el cuidado de un adulto que no puede cuidar de sí mismo) para que alguien en su casa pueda trabajar?

NOMBRE DEL ADULTO QUE TRABAJA	NOMBRE DE NIÑO O ADULTO CUIDADO	¿MENOR DE 2 AÑOS ?	NOMBRE DE LA GUARDERIA O PROVEEDOR DE CUIDADO	CANTIDAD PAGADA	FRECUENCIA (Semana, Quincenal, Mensual, Etc.)
		<input type="radio"/> Si <input type="radio"/> No			
		<input type="radio"/> Si <input type="radio"/> No			



SECCION 4. Prueba de Ingreso

Se le solicitará que provea las pruebas más recientes de todos sus ingresos. Usted puede proporcionar verificación con su solicitud o usted puede elegir ser notificada por correo. Estos son los tipos de información que usted necesita enviar para que su solicitud sea procesada:
 Por el dinero que gana por hacer un trabajo o servicio, usted debe enviar: Pago semanal - (4) semanas de talones de pago (4 talones de pago más recientes)—O—Pago Quincenal - (2) talones de pago recibidos cada dos semanas (2) talones de pago más recientes)—O—Semi-Mensual - (2) talones de pago recibidos dos veces al mes (2 talones de pago más recientes)—O—Mensual - (1) talon de pago recibidos una vez al mes (dos talones de pago más recientes)—O—Pago en Efectivo - Carta del empleador firmada por un Oficial de la Empresa en papel con Membrete de la Empresa —O—Anual - Formulario de Impuestos lleno —O—Documentos de Empleado por Cuenta Propia - como Registros Federales de la Declaración de Impuestos o de Negocios incluyendo pruebas de recibos, facturas y compras. Por favor muestre el dinero que recibe cualquier persona en el hogar de algunas agencias, padres o parientes, o de cualquier otra fuente. Esto podría incluir: • **SSI** o **SSA** - Carta de Otorgamiento del año actual • **Cheque de Desempleo** - (4) semanas de talones de pago (4 talones de cheque más recientes) • **Carta de Compensación de Trabajo** - Carta de la Compañía de Seguros reflejando la cantidad que se recibe y la frecuencia, provea el nombre y número de contacto. • **Contribuciones** - una carta firmada y fechada por la persona que le proporciona el dinero, provea nombre, dirección y número de contacto. Provea la cantidad que recibe y con que frecuencia la recibe. • **Sustento de Menores (pagados directamente a usted)** - una declaración por escrito firmada y fechada del padre/madre que paga el dinero, provea el nombre, dirección y número de contacto. Provea cantidad recibida y la frecuencia con la que recibe. • **Sustento de Menores (se paga a través de la corte)** - carta de la corte indicando la cantidad de ingresos recibidos y la frecuencia en la que se recibe. • **Otros Ingresos no Derivados del Trabajo** - una carta firmada y fechada indicando la cantidad y la frecuencia con la que se recibe. Provea nombre, dirección y número de contacto o (4) semanas de talones de pago (4 talones de pagos más recientes).



SECCION 5. Entendimiento/Autorización Declaración Jurada de miembros.

Yo certifico que la información que he proveído acerca de mi familia y los ingresos es verdadera y correcta. Yo entiendo que mi elegibilidad debe ser revisada después de un año de aprobación para continuar los servicios de Planning for Healthy Babies. Prueba de Ciudadanía o estado legal migratorio debe ser verificado para la elegibilidad de Planning for Healthy Babies. El incumplimiento resultara en una denegación de su solicitud. Números de Seguro Social son usados para comparación computarizada con otras agencias a fin de ayudar en la verificación de elegibilidad para Planning for Healthy Babies.

Yo estoy aplicando para Planning for Healthy Babies o Medicaid para mi, yo certifico bajo la pena de perjurio que soy un Ciudadano de los EE.UU. y/o que legalmente estoy presente en los Estados Unidos.

_____ FIRMA DEL SOLICITANTE FECHA DE LA SOLICITUD / /
DD/MM/AA

Yo, junto con mis otros miembros del hogar, deseamos ser considerados para Medicaid para el cual somos potencialmente elegibles.

Yo estoy de acuerdo en asignar al Estado todos los derechos de apoyo médico y al pago de la atención médica de cualquier tercero (hospital y beneficios médicos). Yo estoy de acuerdo en cooperar con el Estado en identificar y proporcionar información para ayudar al Estado en la búsqueda de cualquier tercero que pueda ser responsable en pagar por el cuidado y servicio. Yo entiendo que debo reportar cualquier pago recibido para la atención médica dentro de 10 días hábiles de ser recibido.

Yo soy una madre, padre o tutor legal, yo certifico que el solicitante(s) es/son ciudadano(s) de los EE.UU. y/o esta presente legalmente en los Estados Unidos.

_____ FIRMA DE PADRE/MADRE O TUTOR LEGAL FECHA DE LA SOLICITUD / /
DD/MM/AA

How To Order Understanding Medicaid Booklets

For all Public Health (PH), Division of Family and Children
Services (DFCS), Right from the Start Medicaid (RSM), and
Qualified Providers (QP).
2011



Memi Wilson, DCH Family Medicaid Program Consultant 404-463-0521



Web Access

- Go To:

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

Member Information tab and then to the Member
Notification tab.



Member Information Tab:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH | GEORGIA WEB PORTAL | HEALTH PARTNERSHIP

Refresh session | You have approximately 9 minutes until your session will expire. | Wednesday, February 23, 2011

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Home | **Member Notices** | Find a Provider | FAQ for Members | Register for Secure Access

User Information ?

Login/Manage Account | Login

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NOTE: If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. [Click here to obtain the latest version of the free Adobe Reader.](#)

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Member Notices (5 rows returned)		
Title	Size (KB)	Release Date
Health Check Brochure	1090.30	10/28/2010
Certification of Medicaid Eligibility	76	10/27/2010
Home and Community Services Booklet	8886.70	10/27/2010
Authorized Representative Form	130.40	11/05/2010
Understanding Medicaid Booklet	972.90	02/21/2011

Web Print

- You may print the booklet from the web. PDF file.

Direct Link:

<https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/MEMBER%20NOTICES/UnderstandingMedicaid.pdf>



Contact Us

- You can use the "Contact Us" feature on the web:

DMA 292 (Request for Forms)

- Download form DMA 292 from the web:

Title	Category	Size (KB)	Release Date
DMA-632: Elig. Determination for Pregnancy Related Care	ALL FORMS	23.80	01/10/2011
189 Submittal Form	ENROLLMENT	388.20	01/10/2011
Form 5459 - Member's Release of Information	ALL FORMS	32.60	02/03/2011
Interim Provider Payment Request Form	CLAIMS	31.90	02/03/2011
Medicaid-PeachCare for Kids Provider Information Change Form	ENROLLMENT	36.50	02/10/2011
DMA-292: Request for Forms or Handbooks	ALL FORMS	70.60	03/01/2011

