

# FAQ



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

## MEDICAID OVERVIEW

### The most common Frequently Asked Questions (FAQs) about Georgia Medicaid Program

General Questions

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How to Apply for Medicaid?

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#### General Questions

##### **Q. What is Medicaid?**

A. Medicaid is a health insurance program that pays medical bills for eligible low-income families including pregnant women and women with breast or cervical cancer, foster and adoptive children and for eligible aged, blind and/or those who have disabilities whose income is insufficient to meet the cost of necessary medical services. Medicaid is administered by the Georgia Department of Community Health (DCH) and pays medical bills with State and Federal tax money.

##### **Q. What is Medicare?**

A. Medicare is an insurance program that pays medical bills for people who are over 65 years old or who have disabilities. It is available to people who receive Social Security benefits regardless of how much money they have. It is operated by the Federal government and is paid for with money from the Social Security Trust Fund, which most people pay into while they work. Retired people and those with disabilities pay a monthly insurance premium for Medicare Part B. This is usually taken out of their Social Security check before they receive the check. You can find out more about Medicare at their website [www.medicare.gov](http://www.medicare.gov) or contact them at 1-800-633-4227. You may also contact GeorgiaCares at 1-800-669-8387 for assistance with Medicare questions.

##### **Q. Can I have both Medicaid and Medicare at the same time?**

A. It depends. If you receive Supplemental Security Income (SSI) from the Social Security Administration, you are automatically eligible for Medicaid and often receive Medicare as well. If you receive both Medicaid and Medicare, Medicaid will pay your Medicare premium, co-payments and deductibles. If you have both Medicare and Medicaid, you should show both cards to your medical care provider each time you receive services.

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### Eligibility

#### **Q. Who is eligible for Medicaid?**

A. Many groups of people are covered by Medicaid. Even within these groups, though, certain requirements must be met. These may include your age; whether you are pregnant, have disabilities, are blind, or aged; your income and assets; and whether you are a U.S. citizen or a lawfully admitted immigrant.

When you apply for Medicaid, the requirements listed above will be taken into account before a decision is made.

Your child may be eligible for coverage if he or she is a U.S. citizen or a lawfully admitted immigrant, even if you are not. Eligibility for children is based on the child's status, not the parent's.

In general, you should apply for Medicaid if your income is low and you match one of the descriptions below:

- You think you are pregnant
- You have been diagnosed with breast or cervical cancer
- You are a child or teenager age 18 or under
- You are over the age of 65
- You are blind
- You have disabilities
- You need nursing home care.

Other situations that may make you eligible:

- If you are leaving Temporary Assistance for Needy Families (TANF) and need health coverage.
- If you are a family with children under 19 and have very low or no income and few resources.
- If your income is higher than the limits and you have medical bills you owe (and you are pregnant, under 18 or over 65, blind, or disabled.)
- If a child is in foster care or adopted
- If you or someone in your family needs health care, you should apply for Medicaid even if you are not sure whether you qualify. Some income and resources do not count against you. For example, owning your home may not stop you from getting Medicaid. Every group has its own income limits, which increase on a regular basis.

#### **Q. I am sick and need to see a doctor. Can I get Medicaid?**

A. Perhaps. Medicaid coverage is available to pregnant women, children, elderly persons age 65 or older, disabled persons who cannot work, and low income families with children under age 18. Disability is defined as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or

which has lasted or can be expected to last for a continuous period of not less than 12 months. If you meet one of the listed criteria, you should apply for Medicaid.

**Q. Can I see a doctor before Medicaid eligibility is determined?**

A. You will be responsible for any bills, if you do not communicate with your doctor about your application for Medicaid. It will be the doctor's decision to accept you as a Medicaid patient and file your claim(s) retroactively, if you become eligible. Once you have been determined eligible for Medicaid by the DFCS, you will receive an approval notice in the mail. The medical provider can use information from the approval notice to confirm your eligibility while you are waiting to receive your Medicaid card.

**Q. How can I find out if I can get Medicaid?**

A. You can find out if you qualify for Medicaid or other medical assistance and social service programs by speaking with a representative at your local DFCS office. You may also find DFCS county contact information at [www.dfcs.dhr.georgia.gov](http://www.dfcs.dhr.georgia.gov), click on your county of residence name. Call 404-656-6060 for additional information on Medicaid.

**Q. How long will it take for me to receive my Medicaid card after I have been determined eligible?**

A. You should receive your Medicaid card within one to two weeks of being determined eligible.

**Q. How much income can I receive and still be eligible for Medicaid?**

A. Income is money that you get from working, or money that someone gives you, or checks that you receive, such as a Social Security check, unemployment benefits, child support, retirement benefits or sick pay. Whether your income level qualifies you or your family for Medicaid depends on the size of your family and the Medicaid program for which you are applying.

Income limits are set each year by the federal government to define the Federal Poverty Level (FPL) for different family sizes. In general, if your household income is at or below the current 100 percent FPL for your household size, your family is likely to be eligible for Medicaid. Children from age one to five can qualify for Medicaid benefits when household income is at or below 133 percent of the FPL. Children under age 19 who live in families with incomes at or below the 185 percent of FPL are eligible for low cost health insurance under the Right from the Start Medicaid (RSM) program. Pregnant women and infants under age one qualifies for Medicaid with family income at or below the 200 percent of FPL, and pregnant women count as two (or more) family members.

See our tables of income limits for applying for Georgia Medicaid programs to find out where your family income is, in relation to these income benchmarks.

**Q. If I have private health insurance, am I eligible for Medicaid?**

A. Yes. If your income is low, and you have minor children, you and your children can have private health insurance and still be eligible for Medicaid. You should tell your Medicaid worker about your

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private insurance and provide a copy of your health insurance card for your Medicaid record. If you have both private health insurance and Medicaid, you should show both your Medicaid card and your private health insurance card to your medical provider each time you receive services.

**Q. If I think I am eligible for Medicaid, should I cancel my other health insurance?**

A. No. If you currently pay for health insurance or Medicare coverage or have the option of getting that coverage, but cannot afford the payment, Medicaid can pay the premiums under certain circumstances. You may be eligible for the Medicare Buy-in Program if you receive Medicare. This program pays your Medicare premiums and deductibles.

**Q. Does my Medicaid from another state work the same now that I'm living in Georgia?**

A. No. Medicaid is different from state to state. Contact or visit your county DFCS office for more information.

**Q. I am a 20 year old college student with no health insurance, can I qualify for Medicaid?**

A. Unfortunately, we do not have a program that will fit your needs at this time. However, if you have medical needs in the future, contact the Georgia Partnership for Caring at 1-800-982-4723 for more information.

**Q. Which newborns are automatically eligible for Medicaid?**

A. A child is eligible for Newborn Medicaid if born to a mother eligible for and receiving Medicaid under any Medicaid program including Supplemental Security Income related Medicaid or any Aged, Blind or Disabled Medicaid program, or to a mother receiving Emergency Medical Assistance.

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 one. Eligibility begins with the birth month, regardless of when the agency is notified of the birth.

If the pregnant woman was not eligible for Medicaid when the child is born, that newborn is not automatically eligible for Newborn Medicaid.

**Q. Am I eligible for Medicaid if I have breast or cervical cancer?**

A. In order to qualify for Medicaid for breast or cervical cancer, a woman must be:

- Diagnosed and in need of treatment for breast or cervical cancer
- Low-income (at or below 200 percent of the FPL Income Guidelines). (See table for more information: income limits for applying for Georgia Medicaid programs)
- Uninsured
- Under age 65
- A Georgia resident and
- A U.S. citizen or qualified alien

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Any uninsured, low-income woman who has been diagnosed with breast or cervical cancer should go to the county health department in their county of residence. You may contact Public Health at 404-657-3143 for county health department locations.

**Q. If a woman has a miscarriage, can her prenatal care be covered retroactively and after pregnancy ends?**

A. If a woman applied for or was receiving Medicaid coverage on or before the date of the miscarriage, she is eligible for two months after the pregnancy ends. A woman may be eligible for up to three months of retroactive coverage before the date of application as long as she was financially eligible and pregnant in those retroactive months.

**Q. Who may be eligible for Right from the Start Medicaid (RSM)?**

A. There are two types of coverage for RSM:

- RSM for pregnant women pays for medical care for pregnant women, including labor and delivery and for up to 60 days after pregnancy ends. Pregnant women who qualify are entitled to the full-range coverage of Medicaid services. Services covered include doctor visits, prescription drugs and inpatient and outpatient hospital services.
- RSM for children pays for medical care for children from birth through the last day of the month in which the child turns nineteen (19) years of age. These children may qualify at various income levels depending on age, family size and income. Children who qualify are entitled to the full-range of Medicaid covered services, including doctor visits, health checkups, immunizations, dental and vision care and prescription drugs.

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### Citizenship and Residency

To obtain full Medicaid benefits in Georgia, you must be a Georgia resident and either a U.S. citizen or a legally residing non-citizen. Non-citizens (residing legally or illegally) can qualify for coverage for emergencies and labor and delivery services if income requirements are met. For additional information about eligibility for non-citizens [click here](#).

**Q. Does Medicaid report non-United States (U.S.) citizens to the U.S. Citizenship and Immigration Service (USCIS)?**

A. No. The Medicaid program does not report citizenship information to the USCIS.

**Q. Can children of non-U.S. citizens get Medicaid?**

A. If the children are U.S. citizens, they can get Medicaid if they meet the eligibility requirements.

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**Q. Do non-U.S. citizens who are applying for Medicaid for their U.S.-born children have to prove citizen or legal residency status?**

A. No. If the person applying is not a U.S citizen and is applying for Medicaid for U.S.- born children, they are not required to provide proof of their citizenship status.

**Q. Do non-U.S. citizens need a Social Security number if they are applying for their child who is a U.S. citizen?**

A. No. If non-U.S. citizens apply for Medicaid for a U.S. born child, they do not have to give their social security number. However, the child's social security number must be provided or the applicant must show proof that they have applied for a number for the child.

**Q. What is Refugee Medical Assistance?**

A. The Refugee Medical Assistance program is for those who are classified as refugees by the USCIS and are not eligible for any other type of Medicaid. Refugee Assistance is good only for the first eight months after an individual arrives in the U.S.

**Q. What is Emergency Medical Assistance (EMA)?**

A. Non-U.S. citizens who are not eligible for Medicaid may be eligible for EMA. EMA will only pay for medical costs for an emergency medical condition (e.g., cost of childbirth, labor and delivery, stabilization). Applicants are not required to provide a Social Security number or documentation of immigration status. You cannot be approved for EMA in advance like regular Medicaid or other health insurance. You can receive EMA only when or after you have received the services, so you cannot know if EMA will be approved before you go for care.

**Q. Are interpreters available?**

A. A person who has difficulty speaking or understanding English or who is hearing impaired and is not able to communicate effectively with county DFCS staff, has the right to an interpreter. The cost of the interpreter will be paid by the county DFCS office. The county office must provide an interpreter to you if you need one. Individuals may bring an interpreter with them, such as a bilingual friend or relative.

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### **Q. Who does NOT have to provide additional Citizenship and Identity documentation?**

A. Verification of Citizenship and Identity is NOT required for:

- Newborns whose mother was enrolled in Medicaid on the child's date of birth;
- Newborns whose mother files an application and is determined eligible for Emergency Medical Assistance
- Children receiving Foster Care or Subsidized Adoption assistance under Title IV part E;
- Children for whom child welfare services are made available under Title IV part B;
- Supplemental Security Income (SSI) recipients;
- Individuals who are eligible for Medicare;
- Social Security Disability Insurance (SSDI) recipients. (Those recipients who receive disability insurance benefits under section 223 or monthly insurance benefits under section 202 based on the individual's disability); and
- Refugees, people who have legally sought asylum , and other qualified aliens.

### **Q. Why must I declare that I am a citizen or a national of the United States?**

A. Before enactment of this provision, in order to qualify for Medicaid, the applicant had to declare under penalty of perjury that he or she was a citizen or national of the United States and if not a citizen or national, that the individual was in a satisfactory immigration status. Individuals who declared they were citizens did not have to do anything else to support that claim, although some States did require documentary evidence of such a claim. Individuals who declared they were aliens in a satisfactory immigration status were required to provide documentary evidence of that claim in every state. The new provision requires that the state obtain satisfactory documentation of citizenship. Under the new law, simply declaring your identity and that you are a U.S. citizen is no longer an acceptable practice.

### **Q. What do we mean by “Declare to be a citizen or national of the United States”?**

A. This means that you affirmatively state that you were born in the U.S. or in the Commonwealth of the Northern Marianas, or American Samoa and Swain's Island or if you were not born in the U.S., you have become a naturalized citizen.

### **Q. What is meant by “satisfactory documentary evidence of citizenship”?**

A. This means you must present to your Medicaid agency documents that show you are a citizen of the U.S. and that you are the person you claim to be. To establish U.S. citizenship the document must show that you were born in the U.S. or that you are a naturalized U.S. citizen. To establish your identity the document must provide identifying information for the person named on the document. For naturalized citizens, a copy of your naturalization certificate will be sufficient if the picture on the certificate is clear and readable.

**Q. What if I don't have a birth certificate or driver's license?**  
A. DFCS can accept a number of alternative documents that will establish your citizenship or identity. If you don't have and cannot get documentary evidence of citizenship, you should explain your situation to your Medicaid office as soon as you apply. The Medicaid agency will then explain what alternatives you may use and what assistance can be provided.

**Q. If I had my citizenship documented when I applied for Medicaid, will I have to document my citizenship again?**  
A. No. Generally you will not have to repeat documentation after July 1, 2006 if the Medicaid Agency documented your citizenship before that date and has a record of it.

**Q. May I bring copies of documents that prove I am a citizen?**  
A. States are not permitted to accept copies of satisfactory documentary evidence that you are a citizen. All documents must be either originals or copies certified by the issuing agency.

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**How to Apply for Medicaid?**

**Q. Where do I go to apply for Medicaid?**  
A. There are several ways to apply for Medicaid and other medical assistance programs:

- You can find out if you qualify for Medicaid or other medical assistance and social service programs by speaking with a representative at your local DFCS office. Call the DFCS information line at 404-656-6060 to be directed to the appropriate office where someone can help you. For a list of DFCS locations and address, phone, fax numbers in your county click the following link [DFCS county contact information](#) .
- To apply for Medicaid, you must submit a completed signed application to DFCS. You may print a Medicaid application and submit the completed signed application at any local DFCS office, by mail, telephone, fax or e-mail. Click on the following links to complete and print your application.  
[Get application \(English\)](#)  
[Get application \(Spanish\)](#)
- If you are pregnant or have breast or cervical cancer, you may apply for Presumptive Medicaid at your local health department. Please call 404-657-3143 to find an office near you.

**Q. Where do I go to apply for Right from the Start Medicaid?**  
A. RSM applications are taken at local county DFCS offices, various other community locations such as hospitals, health departments, medical centers, schools, churches and RSM Outreach Project team offices. Applications are taken at convenient times - prior to, during and after 8 a.m. to 5 p.m. business hours. Contact the RSM Outreach Project at 1-800-809-7276 for locations to apply.

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### **Q. Where do I go to apply for Women's Health Medicaid for breast or cervical cancer patients?**

A. Any uninsured, low-income woman who has been diagnosed with breast or cervical cancer should go to the county health department in their county of residence. You may contact Public Health at 404-657-3143 for county health department locations. Information about the program can also be obtained from the Georgia Cancer Control Section by e-mail [cabroom@dhr.state.ga.us](mailto:cabroom@dhr.state.ga.us) or by telephone 404-657-3156.

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### **Additional Medicaid Questions**

### **Q. What medical services does Medicaid cover?**

A. The Georgia Medicaid program pays for many medical services to keep you healthy and to treat you when you are sick. The major services are:

- Prescriptions
- Doctor visits
- Inpatient and outpatient hospital care
- Lab tests
- X-rays
- Home health care
- Hospice care
- Medical equipment and supplies
- Non emergency medical transportation services
- Dental care (up to age 21)
- Covered services for the Georgia Medicaid are listed on the Medicaid Benefits page.

### **Q. How long will my Medicaid benefits remain active?**

A. Medicaid is based on month to month eligibility. However, your benefits are reevaluated on a yearly basis for aged, blind, disabled Medicaid and every six months for family Medicaid by DFCS to confirm whether you still remain eligible for the program you have. You will receive a Review Form in the mail with instructions. You need to return the Review Form by the date indicated on the accompanying letter or your Medicaid case may be closed.

### **Q. When receiving Medicaid benefits, what changes should my household report?**

A. It is extremely important that you report changes so that your household receives the correct benefits. Medicaid programs require you to report changes in your situation within 10 days of the change.

You must report things like moving to a new address, new income, starting or leaving a job, people moving in or out of your home, medical deductions, purchase of vehicles, monies from child support,

social security or other programs. You may report the information to your local county office by calling, writing a letter or sending in a change report form, which is provided by DFCS.

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### Medicare Savings Plans Programs

**Q. I'm eligible for Medicare and was told to contact Medicaid about paying my monthly premium. How can I do this?**

A. You may qualify for one of the Medicare Savings Plans programs. Based on your income, the MSP program may pay your Medicare premium, co-insurance and deductible. Other MSP programs pay only your Medicare premium. Contact or visit your county Department of Family and Children Services (DFCS) office for an application and to see if you qualify for one of the MSP programs.

- You may qualify for help with certain Medicare costs under one of the Medicare Savings Plans (MSP) programs below if:
- you receive Medicare;
- your income is limited; and
- your resources are not more than \$6,600 for one person or \$9,910 for a couple.
- Contact your local county (DFCS) office to apply and find out if you qualify for one of these programs.

**Q. What is the Qualified Medicare Beneficiary (QMB) Program?**

A. The Qualified Medicare Beneficiary (QMB) program was designed to fill the gaps in Medicare coverage by eliminating out-of-pocket expenses for Medicare covered services. The QMB program helps low-income Medicare beneficiaries by paying Medicare premiums, deductibles and coinsurance.

**Q. What is the Specified Low-Income Medicare Beneficiary (SLMB) Program?**

A. The SLMB programs will pay monthly Medicare Part B premium only.

**Q. What is the Qualifying Individual Program (QI)?**

A. The QI program pays the monthly Medicare Part B premium only. QI has a higher income limit than SLMB but provides the same benefit.

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### **Q. What is the Qualified Disabled Working Individual Program(QDWI)?**

A. The QDWI program will pay monthly Medicare Part A premiums.

If you are under age 65, disabled and no longer entitled to free Medicare Hospital Insurance Part A because you successfully returned to work, you may be eligible for a program that helps pay your Medicare Part A monthly premium.

To be eligible for QDWI, you must:

- continue to have a disabling impairment;
- sign up for premium Hospital Insurance (Part A);
- have limited income;
- have resources worth less than \$4000 for an individual and \$6000 for a couple; not counting the home where you live, usually one car and certain insurance; and
- not already be eligible for Medicaid

### **Q. Who is eligible for these programs?**

A. Medicare beneficiaries are eligible for these programs if all of the following criteria is met:

- You must be a citizen or legal resident of the United States and the State of Georgia and be enrolled in Medicare Part A or be eligible to enroll in Medicare Part A.
- You can participate in these programs even if you are not covered now by Medicare Part A or Part B, as long as you are eligible to enroll. To be eligible to enroll, you must be a citizen of the U.S., or a permanent legal resident for at least 5 years and be at least 65 years old or disabled.
- You do not exceed the asset limits.  
For the Medicare Savings Plans programs: A single person can have no more than \$6,600 in liquid assets (\$9,910 for a married couple). Some assets are not counted, such as your home, a car, an irrevocable burial account up to \$10,000 each for you and your spouse, and life insurance with a cash value of \$1,500 or less.
- You must have limited income.  
See our tables of income limits for applying for Georgia Medicaid programs to find out where your income is, in relation to these income benchmarks.

### **Q. How do I apply for these programs?**

A. To apply, you only need to complete a short application form. The eligibility worker may request additional information if they have questions. You can call or visit your local DFCS office for an application (form 700).

Effective January 1, 2010 an application for the Low Income Subsidy (LIS) or Extra Help with the Social Security Administration is also an application for the MSP programs. Beginning January 1, 2010 you will not need to complete a separate application to apply for assistance with payment of your Medicare premium.

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### **Q. When do benefits start?**

A. QMB benefits start the month after the month of eligibility determination. However, in certain cases, SLMB, QI and QDWI benefits may be granted up to 3 months before the month of application. This means that you could get back up to 3 months' worth of all or some of the premiums that you paid out before you applied for these programs.

If you have additional questions about the Medicare Savings Plans Programs, please contact your local DFCS office, GeorgiaCares at 1-800-669-8387 or Medicare at 1-800-MEDICARE (1-800-633-4227).

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### **Who Do I Contact?**

#### **Q. How do I contact the DFCS Call Center to report a change?**

A. Medicaid members may call 1-877-423-4746 to report changes.

#### **Q. If I have a question about my Medicaid application who should I contact?**

A. Once you apply for Medicaid you will be assigned a Medicaid Eligibility Specialist to complete your eligibility determination. You should contact your assigned Medicaid Eligibility Specialist. If you are unable to reach your Medicaid Eligibility Specialist, please ask to speak to the Medicaid Eligibility Specialist's supervisor. You should always make notes of your inquiries and who you have spoken to.

#### **Q. Is there an general agency contact list?**

A. Yes, please see Phone Numbers and Links contact list.