

PART II

**POLICIES AND PROCEDURES
AFFORDABLE CARE ACT
FOR
PRESUMPTIVE ELIGIBILITY
WOMEN'S HEALTH MEDICAID**



**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE PLANS**

Published: July 2019

Policy Revisions Record
Part II Policies and Procedures Manual for
Women's Health Medical Assistance Eligibility Program
2019

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION (Revision required by Regulation, Legislation, etc.)
			A=Added D=Deleted M=Modified	
3/11/2019	204 Summary of Process	Training Dates	Updated	
3/11/2019	603 Income Eligibility Limits	FPL Chart	Modified	
3/11/2019	Appendix A	Questions & Answers: Breast Reconstruction Protheses	Added	
3/11/2019	Appendix E – Examples	Added language that PE ends the day the Morrow office makes an official eligibility determination.	Added	
		Examples of ineligibility after Morrow makes an eligibility decision.	Added	
		Marcy's income updated to reflect ineligibility based new FPL	Modified	
		Change FPL for Michele Brown	Modified	
		SSI Federal Payment amount for 2019	Added	
3/11/2019	Appendix G - Forms	FPL Memo for 2019	Added	
3/18/2019	Appendix F	DCH letterhead with new Governor's information	Modified	
	305 Fair Hearing Rights	Women's Health Eligibility Specialist	Added	
	306 632W	Change revision date and added Morrow Office	Updated	
	306 “	Added with the exception of dental and vision coverage	Added	
	307 Planning for Healthy Babies	Added Major Medical, exception of dental and vision coverage	Added	
		Added such as Parent Caretaker or ABD/SSI	Added	
	307 Dual Eligibility	P4HB is terminated once the member becomes pregnant and reference to the PE Manual update form section 701.0 Approvals.	Updated	
	307 CMO Passive Enrollment	When a CMO becomes effective, 90 days choice period, number to call and website	Added	
	307 Material	The website where streamline application can be printed.	Added	
	501 Determining Budget Group	Exceptions: Spouses and children are not included in the budget group	Added	

	501 “	Added Step Three	Added	
	Appendix A Questions & Answers	Question 17 regarding breast reconstruction	Added	
	Appendix E budget Unit Composition	Sally’s budget group, Marcy’s example and Jane’s example.	Edited	

**T II- POLICIES AND PROCEDURES
AFFORDABLE CARE ACT FOR PRESUMPTIVE ELIGIBILITY
WOMEN'S HEALTH MEDICAL ASSISTANCE CONTENTS**

CHAPTER 100 INTRODUCTION

Section 101 Goal of Presumptive Eligibility

CHAPTER 200 OVERVIEW OF PRESUMPTIVE ELIGIBILITY

Section 201 Definition and Description of
Presumptive Eligibility Option

Section 202 Summary of Process

Section 203 Certification Process and Liability

Section 204 Responsibilities of a Qualified Provider/
Qualified Hospital

CHAPTER 300 GENERAL PROGRAM REQUIREMENTS

Section 301 Right to Apply

Section 302 Confidentiality

Section 303 Non-discrimination

Section 304 Notice and Informing

Section 305 Fair Hearing Rights

Section 306 Third Party Liability

Section 307 Planning for Healthy Babies (P4HB)

CHAPTER 400 APPLICATION AND ENROLLMENT PROCESS

Section 401 Procedural Responsibilities of
Qualified Providers/Qualified Hospitals

CHAPTER 500 NONFINANCIAL ELIGIBILITY REQUIREMENTS

Section 501 Determination of Budget Unit

Section 502 Citizenship/Legal Immigration Status

CHAPTER 600 FINANCIAL ELIGIBILITY REQUIREMENTS

Section 601	Definition of Income
Section 602	Exempt Income
Section 603	Income Eligibility Limits
Section 604	Determination of Countable Income
Section 605	Earned Income
Section 606	Unearned Income

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

Section 701	On-Line Procedures
Section 701.1	Approvals
Section 702	Manual Approvals
Section 703	Denied Applications

APPENDIX

Section A	Questions & Answers
Section B	Reserved
Section C	Class of Assistance (COA)
Section D	Reserved
Section E	Examples
Section F	Forms
Section G	GAMMIS
Section H	Reserved
Section I	Income
Section J	Reserved
Section K	Reserved
Section L	Reserved
Section M	MEMO
Section N	Reserved
Section O	Reserved
Section P	Planning for Healthy Babies
Section Q	Reserved
Section R	Resources
Section S	Reserved
Section T	Reserved
Section U	Reserved
Section V	Reserved
Section W	Reserved
Section X	(Intentionally Left Blank)

CHAPTER 100 INTRODUCTION

101 Goal of Presumptive Eligibility (PE)

The goal of the Presumptive Eligibility (PE) program is to provide Medical Assistance during the application processing period and remove barriers to the availability of cancer treatment care critical in positively affecting the health of the woman.

The Department of Community Health (DCH) is committed to providing the individuals responsible for determining a PE Women's Health Medical Assistance (WHM) with clear and practical guidelines to:

- Understand Medical Assistance is available to women diagnosed with breast and/or cervical cancer.
- Understand the application process for PE WHM.
- Understand the eligibility requirements to be used in making PE determinations.
- Be able to compute a PE budget using a PE WHM application form 632W.
- To screen on Georgia Medical Assistance Management Information System (GAMMIS) and gateway at <https://gateway.ga.gov> to prevent multiple Member ID numbers being issued.
- To correctly perform on-line entry of the PE WHM application.
- Understand procedures for processing PE WHM applications.

CHAPTER 200 OVERVIEW OF PRESUMPTIVE ELIGIBILITY

201 Definition and Description of Presumptive Eligibility (PE) Option

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

PE is a determination performed by the Qualified Provider (QP)/ Qualified Hospital (QH) which includes the Department of Public Health (DPH), Federally Qualified Health Centers (FQHC), and Rural Health Centers (RHC). Coverage is available prior to a formal determination of eligibility by the local MORROW Right from the Start Medical Assistance Group (MRSM) MRSM team.

PE is an expedited process of enrolling eligible applicants in the Medical Assistance program. It allows QPs/QHs to make a preliminary Medical Assistance eligibility determination on behalf of an applicant. Medical Assistance may be granted to the WHM applicant who meets the Breast and Cervical Early Detection Program (BCCEDP) requirements and WHM requirements. PE consists of an income comparison test using the applicant's statement to establish gross income.

The PE period begins on the date the Qualified Provider/Qualified Hospital determines the applicant eligible. PE period ends when Morrow MRSM 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 WHM, she will receive a temporary Medical Assistance certificate for her first month of eligibility. If the eligibility continues, she receives the plastic Medical Assistance Member Identification Card for newly approved members. If a member was previously issued a Medical Assistance Member Identification Card, she will not automatically be mailed a new card. Replacement cards are requested by the member via online through GAMMIS or by calling DXC Technology at 1-866-211-0950. This number will remain the same throughout the member's eligibility.

These temporary Medical Assistance benefits are available to Georgia female applicants only, which includes a qualified transgendered female to male or a qualified transgendered male to female whom have been diagnosed with breast and/or cervical cancer through the Breast and Cervical Cancer Early Detection Program (BCCEDP).

PE determinations can be completed by QPs/QHs only. The Right from the Start Medical Assistance Group (RSM) and the Division of Family Children Services (DFCS), are not included in the legislation as qualified providers/qualified hospitals; nor do the regulations allow all providers to be certified as qualified providers/qualified hospitals to perform PE determination.

After the PE application determination has been completed, the QP/QH will assist applicants to obtain the following forms:

1. A signed Medical Assistance application form 94
2. Declaration of Citizenship/Immigrant Status form 216 (page 3 of form 94)
3. HIPAA form 5460, and a third party liability information form DMA 285, when necessary.

These forms, along with a copy of the PE WHM application form 632W and Certificate of Diagnosis will be forwarded to the MRSM team for a formal determination of Medical Assistance eligibility. Procedures for routing forms daily to MRSM must be emailed to womenshealth@dch.ga.gov.

Do NOT give anything to DFCS or to the Right from the Start Medical Assistance Group (RSM), everything is handled by MORROW (MRSM) WHM's Health Team.

The completed PE WHM application packet must be received at the MRSM office the same day the PE WHM application is taken; email the PE WHM packet directly to MORROW at womenshealth@dch.ga.gov.

202 Summary of Process

The PE process involves the Qualified Provider (QP)/Qualified Hospital (QH), the Department of Community Health (DCH), the Georgia Medical Assistance Management Information System (GAMMIS), and the MORROW Right from the Start Medical Assistance Group (MRSM) team. The QP/QH determines eligibility for the presumptive period, the MRSM office determines eligibility for ongoing and retroactive Medicaid, and DCH/GAMMIS issues the Medical Assistance member certification card and provides reimbursement to participating providers for Medical Assistance approved services.

The process begins when the applicant enters the QP's/QH's office and requests Medical Assistance. The QP/QH obtains enough information to determine income eligibility and establish if she is qualified for the Breast and Cervical Cancer Program (BCCP). Additionally, the QP/QH assists the applicant in completing an application for ongoing and retroactive Medical Assistance eligibility, as well as, obtaining third party resource information when necessary after the PE WHM determination has been completed.

After this PE WHM activity is approved, the eligible member is given a temporary Medical Assistance certificate. The QP/QH sends the completed PE WHM application packet to the MRSM office. Upon receipt of the PE packet, the Medical Assistance application will be entered in Gateway and eligibility will be determined. Retroactive months are available to members who have a confirmed diagnosis three months prior to the application date. 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 and an open record is established for the member for payment of claims. When the DCH/GAMMIS is notified by the MRSM office of the results of the Medicaid determination, the record is continued as an active Medical Assistance record if eligible or the PE WHM is closed if ineligible.

Subsequent changes of address and/or loss of their Medical Assistance card should be reported by the member to the DXC Technology Member Contact Center at 1-866-211-0950, or directly to their MRSM Medicaid Specialist. If the beneficiary's last name begins with the following alphabet the member should contact the number listed below:

A - D (770)-960-2088 **E - I** (770)-960-2078 **J - N** (770)-960-2092
O - S (770) 960-2084 **T - Z** (770) 960-2081

203 Certification Process and Liability

Providers who meet the requirements of participation will be given the opportunity to become a Qualified Provider (QP)/Qualified Hospital (QH). The training requirement is met by attending a presumptive workshop and satisfactorily performing the training exercises.

Upon completion of the training, each provider certifies that all QP/QH requirements have been met by completing the QP/QH enrollment form. Upon receipt of the enrollment form, the DCH Provider Enrollment Unit will add the QP/QH specialty code to the provider's file and issue an approval notice to the provider showing the effective begin date for performing QP/QH activities.

A provider interested in becoming a QP/QH should contact:

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

Call toll-free 1-800-766-4456 or online 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](#)

204 Responsibilities of a Qualified Provider/Qualified Hospital

- Make correct determinations of PE WHM;
- Notify the MRSM office and the DCH/GAMMIS the same day of PE determination results;
- After the PE WHM application determination is completed, assist the applicant with completing a signed Medical Assistance application form 94;
- Inform the applicant in writing of the results of the PE WHM determination;

2019 PE WHM VICS Training Schedule 10:00 a.m. to 4:30 p.m.

Revised
3-11-19

TRAINING DATES:

April 18, 2019

July 11, 2019

October 24, 2019

All state QPs agencies such as Department of Public Health (DPH), Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) can contact their local DPH office to see if they can attend the VICS training at that office. All other QPs/QHs will need to email pecorrections@dch.ga.gov to make arrangements to attend the training at the DCH State office in Atlanta.

Participants should have PE WHM knowledge before participating in training which includes, but not limited to:

- PE WHM Manual review
- PE WHM Forms review
- The PE WHM processes/procedures for your office
- Non-financial eligibility criteria (Citizenship/Immigration status; residency)
- Financial eligibility criteria (Income; disregards; FPL)
- Basic Budget Groups understanding
- Basic P4HB understanding

CHAPTER 300 GENERAL PROGRAM REQUIREMENTS

301 Right to Apply

§435.906 Opportunity to apply.

Any applicant will be given the opportunity to apply for Medical Assistance benefits without delay.

A PE WHM application may be made at any time BCCP requirements are met, even if there is a Medical Assistance application pending at the county DFCS office.

If the applicant is already active in another Medical Assistance class of assistance (COA), inform the applicant she is already active. PE is a temporary Medicaid; therefore, do not complete a PE WHM application when the applicant is already active on full Medical Assistance except for Planning for Healthy Babies (P4HB) aid categories 180-181. Refer to Appendix C for a brief overview of the COA.

If the member is active on P4HB complete the PE WHM application and send the Manual Update form to PE Corrections to have the P4HB terminated in GAMMIS. Do not refer these members back to DFCS. If the member is active on WHM and becomes pregnant, she can go online at www.gateway.ga.gov and update her pregnancy due date or contact MRSM so that her pregnancy due date can be updated in Gateway.

The applicant is the primary source of information regarding PE WHM. The QP/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 WHM. An applicant may not be refused a PE WHM application if they are not a United States citizen; have not been 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 DMA 632W and informed that their PE WHM application will be denied initially; however, the Medical Assistance application will be reviewed by the MRSM team and the

applicant will be notified of the final disposition of the Medical Assistance 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. This information may not be disclosed to any persons or agencies other than those directly related to the administration of Medical Assistance known as covered entities.

DCH, MRSM, RSM, DFCS, QP/QH 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?

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 is 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 5460.

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 Medical Assistance program.

The Department of Community Health (DCH) does not allow any applicant to be denied PE WHM 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 WHM determination. She must receive notice that her application for Medical Assistance has been forwarded to the MRSM for a formal determination of eligibility.

Follow the process lined out in Chapter 700 for approvals or denials.

305 Fair Hearing Rights

§431.205 Provision of the hearing system

An applicant is entitled to a fair hearing when the MRSM Women's Health Eligibility Specialist makes a determination on her application for Medical Assistance benefits.

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

306 Third Party Liability

§433.145 Assignment of rights to benefits—State plan requirements/SPA ATTACHMENT 2.6-A Page 3a

Applicants must identify any third party that is or may be liable to pay all or part of the medical cost of services of an applicant.

TYPES OF THIRD PARTY LIABILITY INCLUDE BUT ARE NOT LIMITED TO:

- A health benefits provider
- An individual voluntarily paying the medical expenses of the applicant
- Any organization providing medical services for its members

SOURCES OF THIRD PARTY LIABILITY INCLUDE:

- Employers
- Unions and professional organizations
- Pension funds or associations
- Tort action
- Medical support

This list is not all inclusive

The information reported by the member should be recorded on the form DMA 285 (Third Party Liability Questionnaire) and included in the PE WHM packet forwarded to the MRSM team.

If the applicant does not have a Third Party Liability (TPL) have them complete the form DMA 285 indicating no TPL. Make sure the applicant signed application form DMA 632W with a revision date of 06/01/2018 or later and send it with your WHM application package to the Morrow office.

Revised
5-28-19

A copy of the form DMA 285 is located in Appendix F and on the Web.

*****Per Federal regulations if an applicant has major medical coverage, and is not considered underinsured, she is not eligible for PE WHM.**

Please refer to Appendix F- Forms for the complete instructions for the DMA 285 form.

307 Planning for Healthy Babies (P4HB)

Center for Medicare & Medicaid Services, Special Terms and Conditions

The Planning for Healthy Babies (P4HB) Demonstration that covers Family Planning services to women ages 18 through 44, income at or below 211 percent of the federal poverty level (FPL) family size based on Modified Adjusted Gross Income (MAGI), who are not covered by major medical insurance, (except dental and vision coverage) including Medicare and not otherwise receiving benefits under another Medical Assistance program including PeachCare for Kids. 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 Medical Assistance such as Parent Caretaker or ABD SSI and delivered a very low birth weight baby, may receive services in the Resource Mother component of P4HB. P4HB is a demonstration that began on January 1, 2011.

Revised
5-28-19

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 Medical Assistance costs by reducing the number of unintended pregnancies.

There are three levels of service under P4HB – 181 - Family Planning Services, 180 - Inter-Pregnancy Care Services, and 182/183 - Resource Mother Services.

See P4HB MEMO in Appendix M,

All applicants for PE WHM 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 (Numident). 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.

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 WHM or full WHM is approved, the member will have two (2) aid categories active for the same eligibility span on GAMMIS; during this period, the member's P4HB will have to be terminated the same day in GAMMIS when the PE WHM is approved. Please refer to 701.0 Approval section PE CORRECTIONS: Presumptive Eligibility manual updates.

Revised
5-28-19

CMO PASSIVE ENROLLMENT

PE Women's Health members are immediately enrolled in a Care Management Organization (CMO). The CMO plan will show the next day after approval. All services should be billed under the CMO. If the member's CMO is not the plan of her choice, she has 90 days to change her CMO. If she doesn't, she will not be able to change her CMO for one year. The member can contact Georgia Families by phone at 1-888-GA-Enroll (1-888-423-6765). Calls are received Monday thru Friday from 7 a.m. to 7 p.m. Or she can go on the website at <https://www.georgia-families.com>

MATERIAL

Applicants can apply online, www.gateway.ga.gov, for P4HB if QP/QHs do not have any paper applications on hand. A Streamline 94A fillable application can be printed from the website at <https://medicaid.georgia.gov/planning-healthy-babies> or apply by calling 1-877-427-3224 or request an application be mailed. Applications and posters are no longer being printed for distribution. A PDF copy of the P4HB postcard is located in Appendix P.

CHAPTER 400 APPLICATION AND ENROLLMENT PROCESS

401 Procedural Responsibilities of Qualified Providers/Qualified Hospitals §435.1103 Presumptive eligibility for other individuals

The PE process involves several steps from the point of application with the QP/QH through the final disposition of the applicant's Medical Assistance application by the MRSM office.

1. The QP/QH shall conduct an interview with the applicant at which time the provider shall:
 - Advise the applicant she may be eligible for Medical Assistance benefits as a presumptively eligible WHM and as a WHM member for ongoing and retroactive Medical Assistance;
 - Obtain adequate information from the applicant to complete the PE application form DMA 632W, the declaration of citizenship form 216, and the HIPAA form 5460;
 - Determine if the applicant meets the PE WHM eligibility criteria;
2. For any applicant determined presumptively eligible, the QP/QH shall:
 - Perform on-line entry of the application or forward a copy of the completed PE WHM application form DMA 632W to GAMMIS the same day PE WHM application was completed; for data entry by DCH PE Correction box when a QP/QH does not have internet access to GAMMIS;
 - Provide the applicant with a temporary Medical Assistance certificate, or form DMA 634W Approval Notice of Action if the certificate cannot be printed;
 - Obtain adequate information to complete the Third Party Liability Questionnaire (DMA 285); including applicant's signature in both sections indicated at the bottom of the form, if the applicant has health insurance or some other third party provider.

Revised
5-28-19

- Assist the applicant in completing the regular Medical Assistance application form 94 and obtain the applicant's signature. If the applicant has proof of identity and/or citizenship obtain a copy for the Medical Assistance application. Write "viewed and copied" on each copy, stickers may be used. Refer to section 502 for the complete list of acceptable identity and/or citizenship/immigration documents.
- Forward a copy of the completed PE WHM application form DMA 632W, the signed Medical Assistance application (form 94), form 216 Declaration of Citizenship/Immigration Status, form 5460 HIPAA and the Third Party Liability Questionnaire form DMA 285, if appropriate, to the MRSM office the same day completion of the PE WHM application.
- Inform the member of the PE time limit and the services covered;
- Provide the member with a copy of the Medical Assistance Guide and fact sheet, "Quick Guide on Women's Health Medicaid", which explains the program and gives additional information;
- Provide the beneficiary with the address and telephone number of the MRSM Medicaid Specialist where her application has been sent.
- Inform the member about Planning for Healthy Babies (P4HB).
- Give the member the Understanding Medical Assistance.

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

- Inform the applicant verbally and in writing via form DMA 634W Denial that she is not presumptively eligible;
- Advise the applicant that if her circumstances change, she may have another determination of PE WHM performed by a QP/QH;
- Assist the applicant in completing the regular Medical Assistance application form 94 and obtain the applicant's signature. If the

applicant has proof of identity and/or citizenship/immigration documents obtain a copy of the Medical Assistance application form 94. Write “viewed and copied” on each copy, stickers may be used. Refer to section 502 for the complete list of acceptable identity and/or citizenship documents.

- Inform the applicant that her application for Medical Assistance form 94 has been forwarded to the MRSM office for a formal determination of eligibility;
- Forward the signed, DMA 632W and a Medical Assistance application (form 94), the Third-Party Liability Questionnaire (DMA 285), if applicable, form 216 Declaration of Citizenship/Immigration Status and form 5460 HIPAA to the MRSM office; copy of the denial DMA 634W form.
- Provide the applicant with the address and telephone number of her MRSM Medicaid Specialist. Inform the applicant about Planning for Healthy Babies (P4HB).

For any certified presumptively eligible member who reports a lost/ stolen card the QP/QH shall:

- Advise the member to contact **DXC Technology Contact Center (1-866-211-0950)**

OR

- Advise the beneficiary to contact their **MRSM Medicaid Specialist**. If the beneficiary’s last name begins with the following alphabet, they should contact the number listed below:

A - D (770)-960-2088 **E - I** (770)-960-2078 **J - N** (770)-960-2092
O - S (770)960-2084 **T - Z** (770) 960-2081

A change of address should be reported to DCH through PE Manual Updates form; correct addresses are needed so members can obtain Medical Assistance notifications, Medical Assistance cards, their Care Management Organization (CMO) choice selection and ongoing information, and for NET (non-emergency transportation), etc.

The reported change information is included in the Quick Guide form to be given to all approved PE applicants. QP/QH should clearly go over this information.

The Women's Health Medical Assistance Program Fact Sheet is given to all approved PE Applicants. QP/QH should clearly go over this information and provide the applicant with her caseworker's information.

Approved PE beneficiaries will be assigned a CMO and will have 90 days to change their CMO (WellCare, Amerigroup, Peach State or Care Source). Inform them to talk to providers regarding which Medical Assistance they accept so they know which CMO to choose. The CMO information is included in the Quick Guide form to be given to all approved PE applicants. QP/QH should clearly go over this information.



***Information for Providers Serving Medicaid Members
in the Georgia Families 360⁰ SM Program***

Georgia Families 360⁰ SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360⁰ SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360⁰ SM Every member in Georgia Families 360⁰ is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids*	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies*	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids* members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids* premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. All four CMOs are State-wide.

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6763) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women

171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
243	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB <= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DHACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance

147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
213	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver

662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qus. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.caresource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a

Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact DXC at 1-800-766-4436 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. DXC will not be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2013, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360^o program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with credentialing and recredentialing by dialing 1-800-766-4436.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for clean claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for <u>clean</u> claims that have been adjudicated. <u>Pharmacy</u> : Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for clean claims to providers on Monday and Wednesday. For further information, please refer to the Peach	WellCare runs claims payment cycles up to six (6) times each week for clean claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer

enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. Dental: Checks are mailed weekly on Thursday for clean claims. Vision: Checks are mailed weekly on Wednesday for clean claims (beginning June 7th) Pharmacy: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)		State website, or the Peach State provider manual.	Service at 866-231-1821
---	--	---	--------------------------------

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

	moral or religious objections • PCP moves, retires, etc.	warrant an immediate PCP change.	
--	---	----------------------------------	--

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24 th day of the month and are effective for the current month. PCP changes made after the 24 th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-434-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.a21.qualtrics.com/jfe/form/SV_cvY0ohqT2VXYod	866-874-0633 www.pshpg.orgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN
Amerigroup Community Care	ESI	003838	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0833
Peach State Health Plan	US Script (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through DXC by calling 1-800-766-4436 or going to the web portal at www.mmis.georgia.gov. DXC will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:
Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6338 (fax)

CHAPTER 500 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

501 Determination of Budget Group

§435.403 State residence/SPA ATTACHMENT 2.2-A Page 23b

Non-income requirements for PE WHM include the National Breast and Cervical Cancer Early Detection (NBCCEDP) screening; being under the age of 65; being uninsured; requires treatment for breast and/or cervical cancer; GA residency; and the declaration of Citizenship/Immigration Status.

In order to determine income eligibility for Presumptive Medical Assistance, 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 income are to be included. The budget group size determines the income limit used.

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 family relationship with the applicant and a financial responsibility (in addition to a residence in the household). The Medical Assistance program holds spouses responsible for spouses and parents responsible for children. Since this program covers only applicants that have met the BCCP requirements, persons included in the budget group must be related to the applicant as her spouse and/or as a child to the applicant.

At a minimum, the budget group consists of the applicant and her spouse (if any). Children of the applicant under age nineteen may be included in the budget group by her choice. Usually, it is to the advantage of the applicant when determining eligibility to include as many persons in the budget group as possible because the income limit increases for each person included. It is not to her advantage to include optional members who have significant income because the income may be greater than the increase included in the standard for the additional person.

The spouse (legal father) is included in the budget group if he is a member of the household. If there is a natural father in the home, he is not included in the budget group. The children of the natural father are not included in the budget group. Only money the natural father contributes to the budget group will be included (as a contribution). The applicant's statement regarding the legal status of the father, as well as his living arrangement, is accepted for determining membership in the budget group.

If there is a natural father in the home and a legal father elsewhere, the applicant cannot choose to include the children of the natural father in the budget unit if any live in the home of the applicant. There is no family relationship between the applicant and these children nor is there any financial relationship.

Children may be included by the applicant's choice. However, to be included, the child (ren) must be the applicant's child (ren). If the child is not the applicant's child (ren), the child cannot be included even if he/she is a member of the household and the applicant chooses to include the child. The applicant may choose to include some children and exclude others if it is to her benefit to do so.

Individuals (spouses or children) receiving SSI benefits are not included in the budget group. Because they are not included in the budget group, no income received by them is included in the income comparison test.

Spouses are responsible for spouses; must be included in the budget group. **Exception:** As mentioned above, spouses or children receiving SSI are not included in the budget group).

Revised
5-28-19

Children follow their parent(s); the applicant may choose to include or exclude a child from the budget group based on her child's income.

Children are considered children until the last day of the month they turn 19 years old.

Step parents are not responsible for stepchildren; stepchildren cannot be included in the budget group.

STEP ONE Start with the applicant and apply the 501 Section Budget Group to determine the applicant's initial Budget Group.

STEP TWO Include the child in the Budget Group if it will assist the PE applicants to become PE WHM eligible.

STEP THREE Exclude the child in the Budget Group if it will cause the PE applicants to become PE WHM ineligible.

Revised
5-28-19

502 Citizenship/Immigration Status

§435.406 Citizenship and alienage

Policy

Citizenship/Immigrant status requirements are part of the PE WHM program. Only U.S. citizens and qualified immigrants may qualify for PE Medicaid. Qualified immigrants that may qualify for Medical Assistance 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 a legal resident immigrant for five (5) years or more.**

The term “refugee” is used when referring to refugees, asylees, Cuban Parolees/Haitian entrants, Amerasians, victims of trafficking and Special Immigrants from Afghanistan and Iraq.

Definition

Refugee - (a) any person outside his or her country of nationality or residence who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution on account of race, religion or political opinion or (b) any person within his or her country of nationality or residence who is persecuted or has a well-founded fear of persecution on account of race, religion or political opinion.

Procedures

QP/QH must have all applicants complete a Declaration of Citizenship/Immigrant Status form 216 (Appendix F), as part of the PE WHM application process. As with income, the applicant’s statement of citizenship/ immigrant status is acceptable. **Verification of citizenship/immigrant status is not required**; however, if the applicant does present proof of status at the PE interview, copies should be made, and one retained in the PE file and one sent to the MRSM office with the PE packet.

If the applicant has proof of identity and/or citizenship obtain a copy of the Medical Assistance application. Write “viewed and copied” on each copy, stickers may be used. Sign/date and list the QP’s/QH’s agency address.

Acceptable identity and/or citizenship documents:

§435.407 Types of acceptable documentary evidence of citizenship

No Identity Required for 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 for 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)
- The 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
- A 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 Medical Assistance showing a US place of birth:
 - Extract of a hospital record on hospital letterhead established at the time of a 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
- An identification card issued by federal, state or local government agencies or entities with a 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 WHM or the right to apply for the program because they cannot provide proof of citizenship/immigrant status. The application should be denied when form 216 indicates that the applicant is not a U.S. Citizen/Naturalized or is not a qualified immigrant. An affirmative entry on the form meets the criteria for citizenship/ immigrant status. If one of these items is completed, the individual will be determined presumptively eligible provided that they met the BCCP requirements; the family income is at or below 200% of the federal poverty level (FPL) income limit; are a Georgian resident; they are under the age of 65; not on Medicare or Medicaid; and not underinsured.

The approved and denied PE WHM applications will be reviewed by the MRSM 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 QP/QH and should be approved if they meet the PE WHM eligibility requirements.

If the applicant is verbally unable to confirm citizenship or that they are not a qualified immigrant, then the QP/QH will deny the PE applicant and give

the PE packet to the MRSM office. QP/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. The applicant cannot be given only the form 216 to complete and denied in the event she does not meet the citizenship/immigrant status requirements.

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

Copies of form 216, in English and Spanish, are contained in Appendix F. Ample copies should be kept on hand. The Medical Assistance application form 94 contains the form 216 at the end of the application. QP/QH do not have to do a separate form 216 if the form 94 with the 216 at the end is completed.

The day the applicant moves to GA, she is considered a Georgia resident. She does not have to have a fixed GA dwelling. A mailing address is required for applicants to receive Medical Assistance notifications, Medical Assistance cards, CMO information, and NET (non-emergency transportation), etc. If she is unable to provide a mailing address inform her the local DFCS office will be assigned as her address and she can obtain her mail at their office.

CHAPTER 600 FINANCIAL ELIGIBILITY REQUIREMENTS

601 Definition of Income

Income is money received by the budget unit from any source. Money received may be earned or unearned. The classification of income as earned or unearned determines the amount of disregards that can be allowed. **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. 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 – Income 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 Exempt Income

There are some income types that are not included in the determination of eligibility because they have been defined as excludable 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, and educational grants, loans, or scholarships. Vendor payments are payments made by a third party directly to whom the applicant is indebted to.

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

603 Income Eligibility Limits

Revised
3/11/19

Income limits for PE WHM are based on 200% of the federal poverty level. The income limit used is determined by the number of people included in the budget unit.

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

FEDERAL POVERTY GUIDELINES March 1, 2019	
FAMILY SIZE	MONTHLY INCOME LIMIT
1	\$2082
2	\$2819
3	\$3555
4	\$4292
5	\$5029
6	\$5765
7	\$6502
8	\$7239

EACH ADDITIONAL PERSON ADD \$737

To be presumptively eligible for Medical Assistance benefits, the net monthly budget group income must not exceed the monthly income limit for the budget group size. Net income must be less than or equal to the income limit to establish eligibility. Net income is gross minus allowable disregards.

The income limits are based on the federal poverty level (FPL) and change each time the poverty level changes. This change 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.

The 200% FPL limit changed effective April 1, 2019, through January 31, 2020.

604 Determination of Countable Income

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

In addition to those income sources identified as exempt or excludable by statute, there are those income amounts that are disregarded from earned and unearned income. These amounts are called income disregards and are subtracted from gross income to determine net income. Net income is the budget group income that is compared to the income limit to determine eligibility.

The disregards from earned income include the following amounts and are the only allowable amounts to be subtracted from income classified as earned income.

- \$90.00 standard work expense
- Dependent care expenses
- Cost of doing business for self-employment

The only disregard allowed for unearned income is for receipt of child support. This disregard is for the budget group, not the individual receiving the support payment. Therefore, only one child- support disregard is allowed per budget group.

- \$50.00 child support disregard

In addition to the disregard for earned and unearned income, the earned income of the applicant's child, who is 18 years old or younger, and employed, is disregarded in full for purposes of determining PE WHM.

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 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 limit, 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 disregards) 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. The net income amount from self-employment may receive the \$90.00 standard work expense disregard.

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 at least 20 hours per week, count the net income (gross income less the cost of doing business) as unearned income. Unearned income is not entitled to the \$90.00 standard work expense disregard.

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.

Each adult individual included in the budget unit who is receiving earned income is allowed the \$90.00 standard work expense disregard to determine countable income. Additionally, each individual who is paying childcare or paying for the care of an incapacitated person in the home can also receive the dependent care disregard.

When both adults are in the home, if only one adult is employed, the applicant must provide an explanation as to why the unemployed adult is unable to care for the child (ren) in order to be eligible for the disregard. The applicant's statement is accepted for PE WHM; however, inform the applicant that they will be notified by MRSM to provide proof such as a medical statement; proof the adult is in school; etc. to continue to be eligible for the disregard.

The actual cost of child-care or dependent care up to a maximum of \$200.00 monthly for each child under two (2) years of age; \$175.00, monthly for a child or dependent over the age of two (2) can be allowed. For purposes of determining age, a child is considered to be age two (2) until the last day of the month they turn three (3) years of age.

See Appendix I – Income for a chart of Earned Income.

606 Unearned Income

Unearned income includes contributions from relatives and others, returns on capital investments (dividends or interest), pensions, annuities, compensation, and child support payments received.

Child support payments received by budget group members are subject to a maximum disregard per budget group of \$50.00, per month. The actual amount of child support is deducted if it is less than \$50.00, per month.

Any cash contributions or gifts to the budget group are included as unearned income. There are no disregards for these items of unearned income. The only disregard of unearned income allowed is the child support disregard.

See Appendix I – Income for a chart of Unearned Income.

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

701 On-Line Procedures

The online process allows certain information contained on the completed PE WHM application (form DMA 632W) to be data entered into the GAMMIS system. Data entry of this information allows immediate update of the DCH/GAMMIS file and immediate generation of a Medical Assistance identification number.

The online process does not eliminate the BCCP requirement, to interview the applicant, and perform the eligibility determination. Further, the online process does not eliminate the completion of appropriate forms. Only certain information contained on the completed PE WHM application form DMA 632W is involved in the automated process.

701.1 Approvals

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

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

1. Data entry 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. If already known to the system use the same ID.
2. If all data are entered correctly, the system will allow the production of a temporary Medical Assistance certificate. Print out two copies of this document. Give the applicant a copy of the temporary Medical Assistance certificate. In addition to serving as a temporary Medical Assistance certificate, this document serves as a notice to the applicant that she is approved for Medical Assistance. For the on-line process, if the temporary Medical Assistance certificate is not printed, use the Notice of Action, form DMA 634W Approval. Instruct the

3. applicant to present this document to her providers as proof of Medical Assistance eligibility.
4. Retain a copy of the temporary Medical Assistance certificate/DMA 643W Approval in the record, along with the PE WHM application DMA 632W.
5. The same day the PE WHM application is completed, fax the PE WHM packet to the MRSM office. The MRSM team will review the member's eligibility for ongoing and retroactive Medical Assistance (if requested).

Only MORROW can complete retroactive Medical Assistance for PE WHM applicants, up to three (3) months prior. The applicant must meet all the eligibility requirements for any month(s) requested. If the Date of Diagnosis (DOD) is not included in any of the three (3) months prior, the applicant will not be eligible for WHM.

The PE WHM packet will include the DMA 285 TPL form when the member has private insurance.

ERRORS DISCOVERED AFTER PE HAS BEEN SUBMITTED

Providers 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 and prevent a member from receiving services.

After GAMMIS 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 DCH.

PE CORRECTIONS: PRESUMPTIVE ELIGIBILITY MANUAL UPDATES

When an issue occurs when trying to add the PE approval to GAMMIS, the following procedures are to be followed:

When an approved PE application cannot be entered in GAMMIS (QP has no internet access or GAMMIS error) or information in GAMMIS needs to be corrected, the QP should follow the below steps:

1. The QP should complete the '**PE Manual Updates**' coversheet. Email the completed cover sheet along with the PE application to DCH. DCH will complete the updates on the same business day if received by 5:00 pm. If received after 5:00 pm or on the weekend, updates will be completed the next business day.
2. **Subject line:** **PE Manual Update** (Make email '**High Priority!**')
3. Give applicant DMA 634/634W – Notice of Action-Approval
4. Send completed PE packet to MSRM WHM Team.

The above procedure is used for any applicant that is active on P4HB at the time of the PE application. You will still complete the PE application, but you will also complete a PE Manual Update coversheet so DCH can close the P4HB case.

If the member is already known to GAMMIS the member will retain their Member ID number; if the member is new to GAMMIS the DXC Member Enrollment will give you the Member ID number.

After you have been given the Member ID number, give the member form DMA 634W Approval letter; include a copy in the PE packet.

The PE Manual Updates form can be found in Appendix F.

702 Manual Approvals

Only approved applications are to be sent to GAMMIS for data entry. **The manual procedure is to be followed when the provider does not have access to the online or Internet application.**

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

1. Upon completion of the PE application, fax **DCH PE CORRECTIONS** to have it manually updated. Give the PE member form DMA 634W Approval, Notice of Action. The member should present these to their medical care and pharmacy providers.
2. Retain a copy of the temporary Medical Assistance certificate/DMA 643W Approval in the record, along with the PE WHM application DMA 632W.
3. The same day the PE WHM application is completed, fax the PE WHM packet to the MRSM office. The MRSM team will review the member's eligibility for ongoing and retroactive Medical Assistance (if requested).

PE Packets Include:

Form 632W

DMA 285, if required

Form 634W Approval (for approvals that didn't allow a temporary Medical Assistance certificate to print)

HIPAA

Medical Assistance Application form 94

Declaration of Citizenship/Immigration Status form 216 (if not included with form 94)

Certificate of Diagnosis

703 Denied Applications

When the PE WHM application is denied, it **cannot** be data entered. Since denied applications cannot be entered into the **GAMMIS** system, they are to be processed in the following manner.

Reasons for denial are: 1) the applicant is not a U.S. citizen or qualified immigrant. 2) The applicant does not meet the BCCP. 3) The applicant's net family income is above 200% of the federal poverty level limit. 4) The applicant is 65 years of age or older. 5) The applicant has Medical Assistance and/or Medicare. 6) The applicant is not underinsured. 7) The applicant is not a Georgia Resident.

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

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

Note: Since denied applications cannot be data entered, all QP/QH offices, including those with Internet access, must follow these procedures for denials.

PE Packets Include:

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

APPENDIX A - QUESTIONS & ANSWERS

1. What forms are needed for a PE application?

- Application form DMA 632W
- Medical Assistance Application 94
- Third Party Liability Questionnaire form DMA 285 if a TPL exists.
- Declaration of Citizenship/Immigration Status form 216
- HIPAA form
- Certificate of Diagnosis

2. Do I need a separate Declaration of Citizenship form 216 if I am using the Medical Assistance application form 94 dated **06/16** or later?

No. The bottom of page two (2) on form 94 has the Declaration of Citizenship information. Page three (3) of form 94 is the form 216.

If the applicant is applying only for Medical Assistance for herself and the Y/N box is checked Y (Yes) for being a U.S. Citizen on page one (1), and the first box on page two (2) is checked above the signature line; and form 94 is signed and dated, then a separate 216 form or page three (3) of form 94 is not required.

Please have the applicant complete page three (3) of form 94 when there is a request to apply for Medical Assistance for the children in the home.

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 who requests PE WHM Medical Assistance must be given an application. Not everyone will be approved for PE, but they must be given an application.

4. What are some reasons for a PE Medical Assistance denial?

- Not meeting the BCCP requirements
- Not being a U.S. Citizen or qualified immigrant
- Not being at or below the 200% FPL income limit
- Not being a Georgia resident
- Not being under the age of 65
- Not being underinsured
- Not being biologically a woman or transgender woman

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

- Inform the member they have been approved.
- Explain what PE WHM Medical Assistance is.
- Explain what PE WHM Medical Assistance covers.
- Explain what a temporary Medical Assistance certificate is and how they should use it.
- Explain the Medical Assistance application form 94 will be given to the MRSM team to make a full Medical Assistance determination, or they can file their application directly with MRSM.
- Explain that income will be reviewed by MRSM on all full Medical Assistance determination or initial applications once received.
- Give the member the Quick Guide and Fact Sheet, Medical Assistance for Women's Health Medicaid, and review the information.
- Inform the member of Planning for Healthy Babies (P4HB).
- Give the member the Understanding Medical Assistance booklet

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 634W Denial Notice of Action and review it with them.
- Explain the Medical Assistance application form 94 will be given to the MRSM team to make the Medical Assistance determination, or they can file their application directly with MRSM.

- Inform the applicant about Planning for Healthy Babies (P4HB).

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

No. If the QP/QH has access to the online web portal internet they **must enter** the application information online. This is also how the temporary Medical Assistance certificate will be generated. If the QP/QH does not have access to the online internet application, then the approved applications are to be sent to **DCH PE Manual Updates**.

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

QP/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, do not complete a PE WHM application online as PE is only temporary Medicaid.

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

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

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

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

QP/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 - GAMMIS.

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

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

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

See Chapter 600 and Appendix I – Income 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 WHM 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 for the following business day. Nor does the right to apply mean everyone is eligible for PE WHM Medicaid.

The right to apply also does not mean that a QP/QH is allowed to approve back to back PE applications.

13. How do I order forms?

- Form DMA 632W can only be printed from the Web.
- Form DMA 285 can be printed from the Web.
- Forms 94, 216 and HIPAA should be obtained through MRSM, RSM or DFCS or on the Web.
- Form 634W can be printed from the Web.

14. What do I do if the member no longer has private insurance, but the web is showing they do?

If a previously reported third-party resource is no longer valid, i.e., is dropped or canceled, 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 HMS.

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

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

The actual verification of the TPL and gathering of information is a post-eligibility process. QP/QH will accept the applicant's statement and submit the DMA 285 to HMS with the top part of the form completed and the applicant's signature below. If the applicant has verification of the cancellation/change include a copy with the DMA 285 to HMS. More information is located in Appendix F in the instruction section for form DMA 285.

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

Beneficiaries should speak to their MCHB regarding P4HB.

Applicants can contact the following information for questions regarding P4HB:

Phone: 1-877-427-3224

Fax: 912-632-0389

www.gateway.ga.gov

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

Qualified Providers, such as the Department of Public Health, or **Qualified Hospitals** should email pecorrections@dch.ga.gov,

regarding any P4HB regulations. Anything regarding claims/codes etc. will need to be handled by the MCHB.

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

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

Adding the information to 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 Medical Assistance eligibility via the Web or by calling DXC mainly through the IVR system or by speaking with the DXC Provider Contact Center. Members having proof of their eligibility is no longer used to validate their eligibility per House Bill 1234.

17.If I'm in need of Breast Reconstruction and Prostheses, is it covered?

Georgia Medicaid will cover a woman for breast reconstructions and prostheses after mastectomy, but it is based on clinical justification and medical necessity documentation by the physician, surgeon or licensed medical professional.

Redetermination for these women are determined yearly for continuous coverage.

Revised
5-28-19

- a. Is a woman who has been off of Women's Health Medicaid (WHM) for a year eligible for breast reconstructions and prostheses after mastectomy?

Yes, as long as she meets clinical justification and medical necessity. This is determined by a Licensed Medical Professional, which includes doctor or surgeon.

- b. How long will she be eligible for breast reconstruction after having a mastectomy if she doesn't have it at the same time of her mastectomy?

There is no length of time given to heal. She may have it at “any time after the mastectomy”.

- c. Would an applicant who has never been on WHM because she had private insurance prior to losing her coverage, be eligible for breast reconstructions and prostheses after mastectomy?

Yes, because she no longer has private insurance and must meet all other points of eligibility for WHM. A Certificate of Diagnosis must also be completed.

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

A Green Card holder (permanent resident) 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."

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.

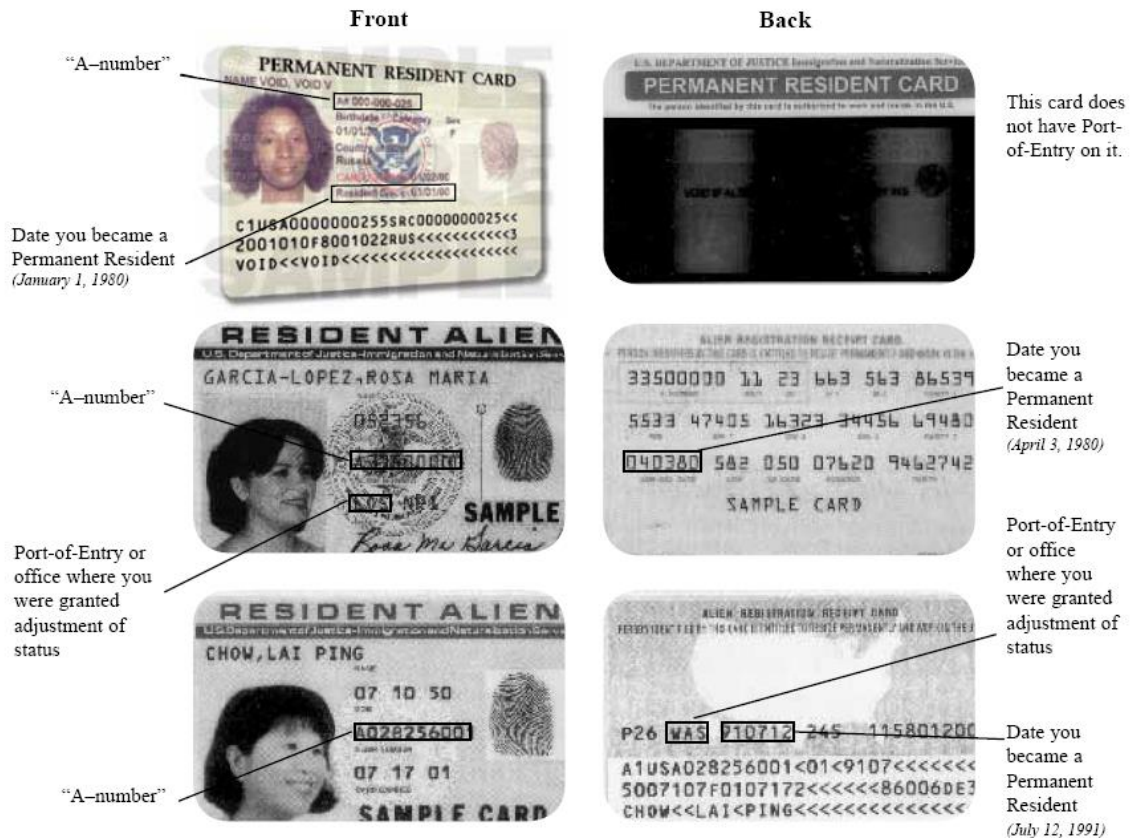
This page can be found at <http://www.uscis.gov/greencard>

19. 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, and facilitates quick and accurate authentication. Beginning May 11, 2010, USCIS will issue all Green Cards in the new, more secure format. USCIS will replace Green Cards already in circulation as individuals apply for green card renewal or green card replacement.





NOTE: The "A-number" is the Alien Registration Number

The U.S. Department of State issues the U.S. passport to U.S. citizens and noncitizen nationals.

Older U.S. Passport

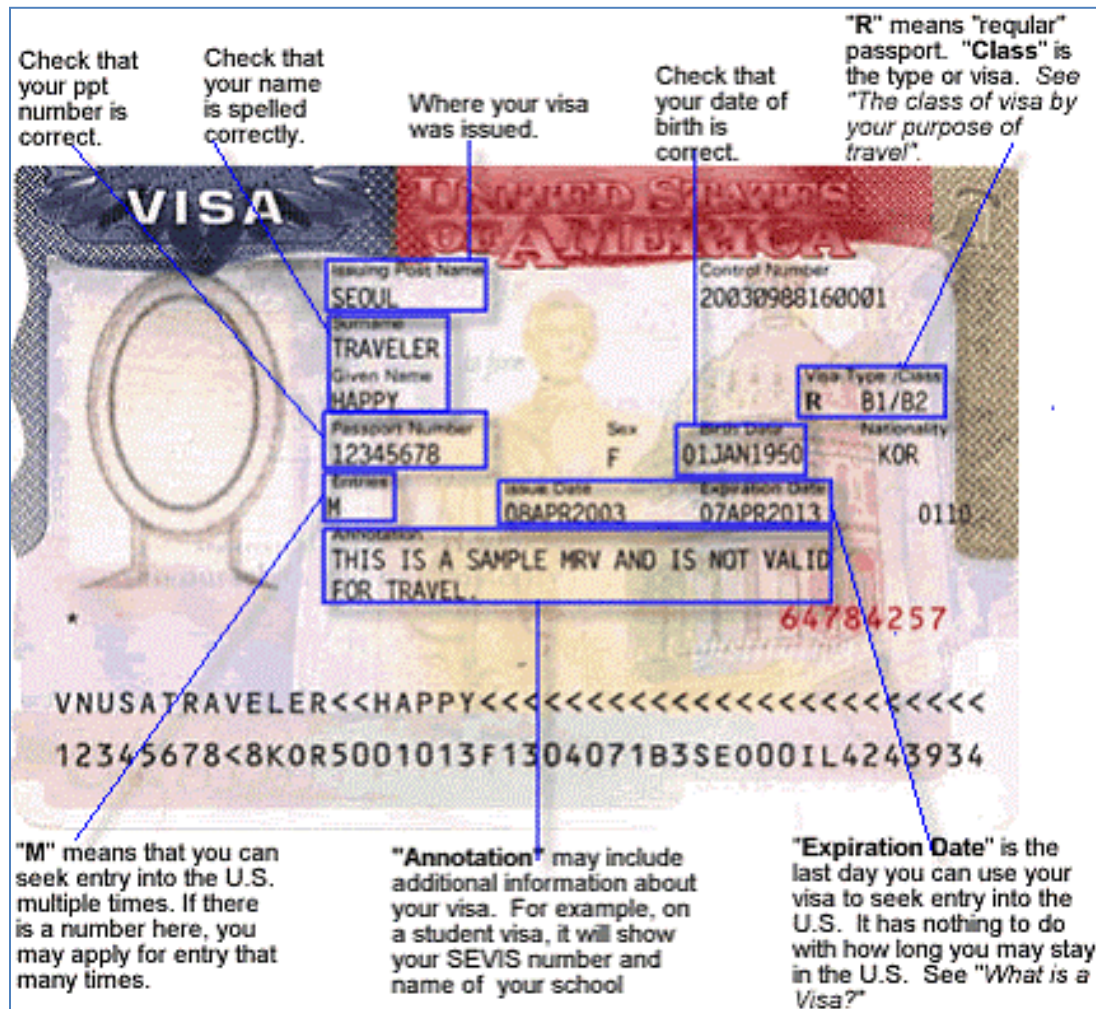


The U.S. Department of State began producing the passport card in July 2008. The passport card is a wallet-size card that can only be used for land and sea travel between the United States and Canada, Mexico, the Caribbean, and Bermuda.



21. How do I read and understand a visa?

The illustrated guide below demonstrates how to read the new Non-immigrant visa (for travel to the U.S. as a temporary visitor).



The temporary Form I-551 MRIV is evidence of permanent resident status for one year from the date of admission.

Temporary I-551 printed notation on a machine-readable immigrant visa (MRIV)

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 the United States. Except for the training required by the course an 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 the USA on a temporary business visa, also known as a **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 an **H4** visa. H4 visa holders are not permitted to work in the 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 the US. It is also known as **B2** Visa. Visitor visa is a non-immigrant visa issued to people entering the US temporarily for pleasure, tourism, or medical treatment. Any foreign citizen including parents who want to visit the 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	Medical Assistance benefits for eligible adults that have a qualifying child.
105 – Parent/ Caretaker Child	Medical Assistance 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	Medical Assistance for up to 12 months to beneficiaries that become ineligible for Parent/Caretaker with Child (ren) Medical Assistance because of changes related to earned income.
122 - 4MEX Adult 123 - 4MEX Child	Four Months Extended Medical Assistance because of Spousal Support. Provides 4 months of Medical Assistance for a Parent/ Caretaker with Child (ren) Medical Assistance member who has become ineligible because of new or increase spousal support.
131 - Child Welfare Foster Care	IV-B Foster Care Medical Assistance 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 Medical Assistance once the child turns 18 years old.
133 - IV-E Foster Care	IV-E Foster Care Medical Assistance 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 Medical Assistance if citizenship/immigration status criteria are met.
135 - Newborn Child	Newborn (NB) Medical Assistance provides Medical Assistance to a child born to a woman who was eligible for and receiving Medical Assistance on the day the child was born. A child is eligible for Newborn Medical Assistance 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 Medical Assistance 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.
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.

140 - PCK/MA IVB Children	Former Peachcare for Kids® members with IVB Medical Assistance 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 Medical Assistance Medically Needy (FM-MN) provides Medical Assistance for children under 19 years of age whose BG income exceeds limits for all Family Medical Assistance and PeachCare for Kids®.
148 - Pregnant Woman Medically Needy Spend Down	Family Medical Assistance Medically Needy (FM-MN) provides Medical Assistance for pregnant women whose BG income exceeds limits for all Family Medical Assistance and PeachCare for Kids®.
170 - 194 - 197 Pregnant Woman	Medical Assistance 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	Medical Assistance 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 Demonstration 180 - P4HB IPC 181 - P4HB Family Planning 182 - P4HB Family RM 183 - P4HB ABD RM	The original Family Planning Demonstration no longer active Planning for Healthy Babies IPC Planning for Healthy Babies Family Planning Demonstration Resource Mother for Family Medical Assistance beneficiaries Resource Mother for ABD beneficiaries
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 Medical Assistance 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 Medical Assistance 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 Medical Assistance 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 Medical Assistance(WHM)	Ongoing WHM for women with breast and/or cervical cancer.
246 GMWD	Georgia Medical Assistance 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 Medical Assistance 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 - Medical Assistance 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 Medical Assistance 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 Assistance for children who are financially ineligible for Medical Assistance. 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/Qualified hospitals only.
835 Presumptive Newborn	Newborn Medical Assistance is given to deemed newborns by 378 providers only.
864 Presumptive Pregnant Woman	Presumptive Pregnant Medical Assistance for a pregnant woman determined by Qualified providers/Qualified hospitals only. (Effective 02/26/15)
865 Presumptive Pregnant Woman	Presumptive Pregnant Medical Assistance for a pregnant woman determined by Qualified providers/Qualified hospitals only. (Discontinued 02/26/15)
801 Presumptive Parent/Caretaker Adult Medicaid	Presumptive Parent/Caretaker Medical Assistance benefits for eligible adults that have a qualifying child.

802 Presumptive Parent/Caretaker Child Medicaid	Presumptive Parent/Caretaker Medical Assistance 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 Medical Assistance 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 Medical Assistance for former foster care beneficiaries that aged out of FosterCare Medical Assistance or CHAFEE Medical Assistance and are no longer eligible for FosterCare Medical Assistance 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 or until a decision is made by the Right from the Start Medical Assistance Group, Morrow Team. The PE will end on the date that Morrow makes an eligibility determination in Gateway.

Revised 3/11/19

2. Ms. Washington applies in your office on 5/1/XX; her 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.

The PE period begins on the approved application date and ends when MRSM determines eligibility or ineligibility for Medicaid, but no later than at the end of the following month of the PE approval.

1. Morrow receives PE application dated 2/11/XX and determines that the applicant is ineligible on 2/19/XX. The applicant PE ends on 2/19/XX.
2. Morrow receives PE application dated 3/11/XX and determines that the applicant is ineligible on 3/11/XX. Applicant PE will end on 3/11/XX.

*The web portal has been updated and coverage no longer reverts to the beginning of the month for Presumptive Eligibility.

Budget Unit 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. Sally visited her local Department of Public Health that verified she met the BCCP requirements. The father of her children is not in the home. Who is included in the budget unit?

- a. Sally is included in the budget unit. Her two children could also be included in the budget group to increase the income limit that will be used to determine financial eligibility. Therefore, the minimum budget group size is one (1) and the maximum budget group size is three (3).
- b. Although Sally is related to the other individuals in the home, they are not included in the budget group and they cannot be included in the budget group per policy.

Revised
5-28-19

2. Marcy Brown lives with her husband, her daughter, two mutual children, and his son. She has met the BCCP requirements. 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. Who is included in the budget unit?

Revised
5-28-19

- a. Marcy is included in the budget unit and her husband is included because he is in the household and financially is responsible for Marcy.
- b. Marcy has chosen to include her daughter, her two mutual children and her stepson. You will inform Marcy that her stepson cannot be included in the budget group per policy because he does not meet the degree of relationship.
- c. She has decided to exclude her daughter and the daughter's income. Therefore, the budget unit size is four, Marcy, her husband and their two mutual children.
- d. If Marcy had chosen to include her daughter, the budget unit size would have been five, and the daughter's child support income would have been included in the income comparison test.

3. Jane Smith lives with her boyfriend and her eighteen-year-old son. Her son has medical problems and is unemployed. Jane has met the BCCP requirements. Who is included in the budget unit?

- a. Jane's budget group can be counted as two, which includes her and her son. Her boyfriend is not included as he is not a spouse and he is not financially responsible for Jane. He is also not the biological father of her son.
- b. Her son can be included in the budget group to increase the income limit for Ms. Smith; however, he can only stay in the budget group until the month he turns nineteen years old.

The month following his 19th birthday he is no longer allowed to be included in the budget group per policy and may affect continued eligibility for the member.

- c. The son should be referred to the Social Security Administration to apply for disability benefits. When Jane completes the Medical Assistance application form 94, MRSM will determine if he is Medical Assistance eligible.

4. Lucy White has met the BCCP requirements. She lives with her disabled husband who receives SSI benefits and a small pension. Their oldest son also receives SSI for disability. The two younger children are healthy and attend school regularly. Lucy is employed as a part-time Avon saleswoman but is unable to work very much because of her son's illness. Who is included in the budget unit?

Lucy is included in the budget group, but her husband is not included as he is receiving SSI benefits. Her oldest son is not included because he is also receiving SSI benefits. She may include the two younger children. Therefore, the minimum budget unit is one and the maximum size is three.

EFFECTIVE FOR SERVICES
 BEGINNING April 1, 2019
 MONTH DAY YEAR

BXC TECHNOLOGY CONTACT CENTER
 P.O. BOX 105200
 TUCKER, GA 30085-5200

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



999988765432
 MEDICAL ASSISTANCE IDENTIFICATION NUMBER

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAL ASSISTANCE

April 1 - May 31, 2019

VALID FOR LISTED MONTH ONLY

APPLICANT'S NAME: Lucy White
 APPLICANT'S ADDRESS: 289 First Street
 APARTMENT/LOT NUMBER: G5
 CITY: Henry STATE: GA

MAIDEN NAME: Franklin
 TELEPHONE NUMBER: (404) 565-6565
 SOCIAL SECURITY NUMBER: 098-76-5432
 (Optional)
 ZIP CODE: 30281 COUNTY OF RESIDENCE: Henry

HEALTH INSURANCE: ☐ YES ☒ NO

APPLICANT'S RECORD: 123ABC

DATE OF INTERVIEW: 04/01/2019

	FAMILY MEMBERS				DATE OF BIRTH MM/DD/YYYY	* RACE	GENDER	RELATION TO APPLICANT	MONTHLY GROSS INCOME				MONTHLY DESREGARDS		MONTHLY NET INCOME
	FIRST NAME	MI	LAST NAME	SUFFIX					TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	STANDARD WORK DESREGARD	DEPENDENT CARE DESREGARD	
01	Lucy A.		White		05/01/64	W	F	SELF				0	0	0	0
02	Cathy B.		White		04/26/10	W	F	Child							0
03	James J.		White		09/12/12	W	M	Child							0
04															
05															
06															

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAL ASSISTANCE AND THAT THE MORROW RIGHT FROM THE START MEDICAL ASSISTANCE (MRSM) GROUP WILL DETERMINE MY CONTINUING ELIGIBILITY.

I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IN THE UNITED STATES AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME.

I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).

I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH ARSM MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY.

I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS.

04/01/2019

Lucy White

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.

04/01/2019

Lorraine Russell

RN

DATE OF COMPLETION

COMPLETED BY (PLEASE PRINT)

TITLE

(404) 651-9978

Lorraine Russell

DIRECT PHONE NUMBER

SIGNATURE OF INDIVIDUAL COMPLETING

FORM 632W (10/24/2017)

TOTAL GROSS INCOME = 0

CHILD SUPPORT DESREGARD = 0

NUMBER IN FAMILY = 3

TOTAL FAMILY NET INCOME = 0

POVERTY INCOME LEVEL = 3,555

Applicant is ☒ ELIGIBLE or ☐ INELIGIBLE for PE WHM.

PROVIDER CERTIFICATION:

I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN DETERMINED WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 106-354 ON 12/26/2018

HER DIAGNOSIS MET THE BCC PROGRAM IN GEORGIA. I HAVE OBTAINED A SIGNED MEDICAL ASSISTANCE APPLICATION FROM THE APPLICANT AND HAVE FAXED IT TO THE MORROW RSM OFFICE AT 770-359-1813.

Lorraine Russell

RN

QUALIFIED PROVIDER SIGNATURE

TITLE

Henry DPH

2332323214P

QUALIFIED PROVIDER NAME

QUALIFIED PROVIDER ID NUMBER

QUALIFIED PROVIDER ADDRESS:

135 Henry Pkwy,

McDonough, GA 30253

Income

Michele Brown lives with her husband, her daughter, and three mutual children. She has met the BCCP requirements. Michele is employed and earns \$2445.00, per month. Her husband is employed as a machinist and earns \$2622.00, per month. Michele receives \$851.00, per month, child- support for her daughter. Determine financial eligibility.

Revised
03/11/19

\$ 2522.00	Mrs. Brown's earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 2432.00	
<u>\$ 851.00</u>	Child Support
\$ 3283.00	
<u>\$ -50.00</u>	Child Support Disregard
\$ 3233.00	Mrs. Brown's net income
\$ 2630.00	Mr. Brown's earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 2540.00	Mr. Brown's net income
\$ 3233.00	Mrs. Brown's net income
<u>\$ 2540.00</u>	Mr. Brown's net income
\$ 5773.00	Total Household Income for BG of 6
	BG of 6 Income Limit = \$5765
	Not PE eligible for Household of 6

Calculate everyone in the BG home first, if the applicant is eligible for all household members then use everyone allowed by policy. The total household net income must be equal to or less than the income limit for the BG.

In this case, since everyone included causes her to be ineligible, let's explore who we can remove. The best place to start is with BG members that have income; however, a spouse cannot be removed. Her daughter has child support if that were eliminated it would create a BG of 5.

\$ 2522.00	Mrs. Brown's earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 2432.00	Mrs. Brown's net income
\$ 2630.00	Mr. Brown's earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 2540.00	Mr. Brown's net income
\$ 2432.00	Mrs. Brown's net income
<u>\$ 2540.00</u>	Mr. Brown's net income
\$ 4972.00	Total Household Income for BG of 5
	BG of 5 Income Limit = \$5029
	PE eligible for Household of 5

Mrs. Jones has met the BCCP requirement. She 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. Determine financial eligibility.

\$ 421.00	Mrs. Jones' earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 331.00	
<u>\$ -175.00</u>	Child- care disregard for three-year-old
\$ 156.00	Mrs. Jones' net income
\$ 960.00	Mr. Jones' earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 870.00	Mr. Jones' net income
\$ 156.00	Mrs. Jones' net income
<u>\$ 870.00</u>	Mr. Jones' net income
\$ 1026.00	Total Household Income for BG of 4
	BG of 4 Income Limit = \$4292
	PE eligible for a BG of 4

Net income is less than the income limit, so Mrs. Jones is eligible for Presumptive Eligibility. She will remain eligible for Medical Assistance benefits until a full Medical Assistance determination of MRSME eligibility is made.

The son's earned income of \$75.00 from his newspaper route is totally disregarded as he is under the age of 19. He is considered a child and per policy, a child's earned income is not counted; however, unearned income would be. The fact that he is a student or employed, regardless if full time or part time, is not relevant per Medical Assistance policy.

Since this is a two-parent household both parents must be employed for the childcare disregard to be given; however, if a parent has good cause for not working, the disregard can be given.

The budget group includes the applicant, her husband, and their two children for a total of 4.

Mrs. Smith has met the BCCP requirement. She lives with her two daughters, Jane, age 9 years, and Debbie, age 13 years. Mrs. Smith is separated from her husband who pays \$300, per month, child- support for their daughter, Jane. Debbie, Mrs. Smith's daughter from a previous marriage, receives \$120 per

month child-support from her absent father. Mrs. Smith earns \$400.00 per month babysitting in her home.

If Mrs. Smith chooses to exclude both children:

\$ 400.00	Mrs. Smith's earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 310.00	Total net income for BG of 1
	BG of 1 income limit = \$2082
	PE eligible for a BG of 1

If Mrs. Smith chooses to include the children:

\$ 400.00	Mrs. Smith's earned income
<u>\$ -90.00</u>	Standard work expense disregards
\$ 310.00	
<u>\$ 300.00</u>	Child- support received for Jane
\$ 610.00	
<u>\$ 120.00</u>	Child- support received for Debbie
\$ 730.00	
<u>\$ -50.00</u>	Child- support disregard
\$ 680.00	Total net income
	BG of 3 income limit = \$3555
	PE eligible for a BG of 3

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

This BG receives two different monthly child support payments; however, only one \$50 disregard is allowed. If the total child support payment is equal to \$50 a month, then the total child support amount to count in the budget is zero. If the total child support payment is less than \$50 then count up to that amount as the disregard.

Child support is the only unearned income that is allowed a disregard. Unearned income is calculated with the same conversion factor as earned income.

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

Pays: \$52 a week for dependent care = $52 \times 4.3333 = \$225.33$
\$52 bi-weekly for dependent care = $52 \times 2.1666 = \$112.66$
\$52 twice a month for dependent care = $52 \times 2 = \$104$

For dependent care regarding a child, their age will determine the maximum allowed amount for this disregard. Each child that dependent care is paid for is allowed their own disregard. A child under the age of 2 is allowed up to \$200 gross monthly, age 2 and older is reduced to \$175 gross monthly. A child is considered 2 years old the month following their 2nd birthday.

Using the \$52 for dependent care, the maximum disregard allowed:

Childcare Dependent Care	Under 2	2 or older
	\$200	\$175
\$52/week	\$200	\$175
\$52/BW	\$112.66	\$112.66
\$52/SM	\$104	\$104

SPECIFIED RELATIVE

Susan has two children, Bobby 16 and Jessica 19 years of age. Jessica has applied for Women's Health Medicaid. Jessica has met the BCCP requirements. Even though she lives with her mother and brother, who meet the specified relative relationship; she is treated as an adult and would be a budget group of one for her.

Susan gets married to Tommy. Tommy has three daughters, Bobbi Jean, Krissy, and Heaven Leigh. Bobby and Jessica move back in the home. Susan has met the BCCP requirements. Susan's budget group must include her spouse, Tommy. Susan can add Bobby to the budget group, but she cannot add any of Tommy's three daughters as they would be her stepdaughters.

Kathy is 21 years old and her best friend Bria just had a baby; Kathy is called "Aunt Kathy". Bria asked Aunt Kathy to watch her baby for a few hours but never came back. Kathy is caring for the newborn. Kathy has met the BCCP requirements. The budget group can only be Kathy. Kathy does not meet the specified relative relationship for Bria's child even though Aunt Kathy is caring for the newborn.

SSI FEDERAL PAYMENT AMOUNTS FOR 2019

<i>Recipient</i>	SSI Monthly Amount 2019	SSI Yearly Amount 2019
<i>Eligible Individual</i>	\$771	\$9,252
<i>Eligible Couple</i>	\$1,157	\$13,884

Revised
03/11/19

Appendix F: FORMS Table of Contents

Form Number	Form Name	Instructions	Revision Date
94	ENGLISH MEDICAL ASSISTANCEAPPLICATION	94i	06/16
94SP	SPANISH MEDICAL ASSISTANCEAPPLICATION		06/16
216	ENGLISH DECLARATION OF CITIZENSHIP	216i	10/18
216SP	SPANISH DECLARATION OF CITIZENSHIP		10/18
DMA 285	HEALTH INSURANCE QUESTIONNAIRE	DMA 285i	01/06
DMA 632W	PE WHM APPLICATION	DMA 632Wi	10/17
DMA 632W Page 2	PE WHM Application Page 2		10/17
DMA 634W	APPROVAL NOTICE OF ACTION	DMA 634i	02/17
DMA 634W	DENIAL NOTICE OF ACTION	DMA 634i	02/17
5460	ENGLISH HIPAA	5460i	04/16
5460SP	SPANISH HIPAA		04/16
	PE Manual Updates		2/18
	SSI Pregnant Woman Update		01/17
	WOMEN'S HEALTH MEDICAL ASSISTANCE PROGRAM FACT SHEET		02/16
	QUICK GUIDE ON WOMEN'S HEALTH MEDICAL ASSISTANCE		03/16
DMA 632WQP	Statement of Treatment		01/18
	Transgender		
	Georgia Families 360		10/2018

INSTRUCTIONS ON FORMS

PRESUMPTIVE ELIGIBILITY WHM APPLICATION:

The Presumptive Eligibility WHM Application is used to record information needed to determine eligibility. If approved beneficiaries are to be given a temporary Medical Assistance certificate as proof of eligibility or use the form 634W Approval if the certificate is not printed.

The form is divided into three parts. The top third of the form reflects demographic information of the member and the month for which the card 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 and the provider, as well as, the budget group income information.

The form should be routed according to the directions given in the instructions for processing applications as of 01-01-2013. If the applicant is not eligible, give the applicant form 634W Denial only. A copy of this form should be kept in the QP/QH's patient file and another copy, regardless of approved or denied, given to MRSM as part of the PE WHM packet.

Completion of Individual Items

Effective for Services Beginning:	Enter application month; enter the day of the application month; enter the year. No difference if the month name is written out or just the numeric numbers for each month is used. No difference if the full four digits of the year are used or only the last two. As long as the full date is clear.
Medical Assistance Identification Number:	List her twelve (12) digit number that begins with 111 or 222.
Valid for Listed Month Only:	Enter the month(s) and year in which the Presumptive Eligibility determination was made. The month of application to the end of the completed month.
Applicant's Name:	Enter the name of the applicant.
Applicant's Maiden Name:	Enter Maiden name of applicant if applicable
Applicant's Mailing Address:	Enter mailing address where the card is to be sent. The dwelling isn't required to be fixed. If she is homeless, advise her that the DFCS address will be used if she cannot provide an address. This is where her Medical Assistance card and notifications will be mailed, and NET will be set to.
City, State, Zip Code:	Self-explanatory. Must be a GA resident.

County of Residence:	Enter applicant's county of residence even if different from provider's county of residence.
Telephone and SS Number:	Self-explanatory. SSN is optional in that if she can't remember her SSN, process the PE application without it. This may cause incorrect duplicate ID numbers.
Patient's Record Number:	For provider's use in identifying patient.
Date of Interview:	Enter the month, day and year applicant provided information for the form.
Health Insurance:	Yes, or No. If she isn't underinsured, she is not eligible for PE WHM.
Family Members:	Enter the applicant's name on the first line. Enter the names of the remaining budget group members on the remaining lines.
Date of Birth:	Enter the birthdates of all budget group members.
Race, Gender, and Relationship to Applicant:	Enter for all members. To be included in the budget group, the individual must be a spouse, a child of the applicant (biological or adopted). *By providing Race information, the applicant will assist us in administering our programs in a non-discriminatory manner. Applicants are not required to give us this information and it will not affect their eligibility or benefit level.
Monthly Gross Income:	<u>Enter the type of income:</u> C= Commissions G= Gifts or Contributions OE = Other Earnings P = Pension SE = Self Employed OU= Other Unearned Income W = Wage or Salary CS = Child Support Refer to Appendix I - Income. <u>Enter amount received and how often:</u> B = Biweekly H = Hourly M = Monthly Q = Quarterly S = Semi-Monthly W = Weekly Y = Yearly D= Daily. Convert all income to a monthly amount.

Monthly Disregards:	Enter \$90.00 for work disregard and either \$200.00 or \$175.00 for dependent care if income is earned and dependent care is purchased.
Monthly Net Income:	Enter net income for each budget unit member by subtracting work disregards from monthly gross income.
Total Gross Income:	Enter monthly total gross income for the budget group.
The Number in Family:	Enter the number of persons included in the budget group.
Poverty Level Income:	Enter the amount of the income limit for the budget group size.
Subtotal Net Income:	Enter the monthly total net income for the budget group
Child- Support Disregard:	Enter the actual amount of child support received up to a maximum of \$50.00 for the group.
Total Family Net Income:	Enter the amount remaining after the child support is subtracted from the net income. Compare this amount to the poverty standard. If income is equal to or less than, check the eligible box. If income is more, check the ineligible box.
Sworn Statement of Applicant:	Have the applicant sign and date the application after she has read or had read to her the declaration of understanding.
Provider Certification:	The provider or designee should sign the form after completing the verification of the BCCP.
Qualified Provider Name:	Full Provider Name.
Qualified Provider ID:	Provider ID number used to complete PE applications on GAMMIS
Qualified Provider Address:	Provider's full mailing address
Direct Phone Number:	The provider's direct phone number of the person that completed the PE application.
Completed By:	The provider's name of the person that completed the PE application
Title:	This provider's title of the person that completed the PE application
Date of completion:	The date the provider completed the PE determination. This date could be different than the actual PE application date.
Signature of Individual completing the form:	The provider's signature of the person that completed the PE application.

EFFECTIVE FOR SERVICES
BEGINNING _____
MONTH DAY YEAR

DXC TECHNOLOGY CONTACT CENTER
P.O. BOX 103200
TUCKER, GA 30085-5200

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



MEDICAL ASSISTANCE IDENTIFICATION NUMBER _____

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAL ASSISTANCE

PE ELIGIBILITY PERIOD _____

APPLICANT'S NAME: _____

MAIDEN NAME: _____

HEALTH INSURANCE: ☐ YES ☐ NO

APPLICANT'S ADDRESS: _____

TELEPHONE NUMBER: _____

APPLICANT'S RECORD NUMBER: _____

APARTMENT/LOT NUMBER: _____

SOCIAL SECURITY NUMBER: _____
(Optional)

DATE OF INTERVIEW: _____

CITY: _____ STATE: _____

ZIP CODE: _____ COUNTY OF RESIDENCE: _____

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

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAL ASSISTANCE. IT WILL END WHEN THE MORROW RIGHT FROM THE START MEDICAL ASSISTANCE (MRSM) GROUP DETERMINES MY ELIGIBILITY OR INELIGIBILITY, BUT NO LATER THAN THE LAST DAY OF THE MONTH FOLLOWING THE MONTH OF THE PE APPROVAL. MRSM WILL DETERMINE MY CONTINUING ELIGIBILITY.

I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IN THE UNITED STATES AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME.

I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).

I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS.

DATE OF APPLICATION _____

APPLICANT'S SIGNATURE _____

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

DATE OF COMPLETION _____

COMPLETED BY (PLEASE PRINT) _____

TITLE _____

DIRECT PHONE NUMBER _____

SIGNATURE OF INDIVIDUAL COMPLETING FORM _____

632W (06/01/2018)

SUBTOTAL NET INCOME = _____

CHILD SUPPORT
DISREGARD= _____

NUMBER IN BUDGET GROUP = _____

POVERTY INCOME LEVEL = _____

TOTAL FAMILY
NET INCOME = _____

Applicant is ☐ ELIGIBLE or ☐ INELIGIBLE for PE WHM.

PROVIDER CERTIFICATION:

I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN DETERMINED WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 106-354 ON _____.

HER DIAGNOSIS MET THE BCCP IN GEORGIA. I HAVE OBTAINED A SIGNED MEDICAL ASSISTANCE APPLICATION FROM THE APPLICANT AND HAVE EMAILED TO WOMENSHEALTH@DCH.GA.GOV OR FAXED TO 770-359-1813.

QUALIFIED PROVIDER SIGNATURE _____

TITLE _____

QUALIFIED PROVIDER NAME _____

QUALIFIED PROVIDER ID NUMBER _____

QUALIFIED PROVIDER ADDRESS: _____

APPLICANT'S NAME: _____ MEDICAL ASSISTANCE IDENTIFICATION NUMBER: _____

[illegible]

SPECIAL NOTE TO MEMBER:

If you have not heard from your MRSM Medical Assistance Specialist about your application for Medical Assistance within thirty (30) days, please contact them.

INSTRUCTIONS TO MEMBER:

This certification can be used to receive medical assistance for only the applicant listed on the temporary Medical Assistance 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 MRSM Medical Assistance Specialist. 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. Verify eligibility on GAMMIS or by using the IVR system. 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 MEMBER:

Your eligibility under this special program stops when the MORROW Right from the Start Medical Assistance Group (MRSM) Project makes the decision for your continuing eligibility. When you applied for PE WHM, you may also have applied for Healthcare coverage. When a decision is made on your WHM (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 Medicaid, you are not entitled to a hearing when your presumptive coverage stops.

MEDICAL ASSISTANCE APPLICATION FORM 94:

This form is used to apply for ongoing and retroactive Medical Assistance benefits. The applicant must sign and date this application, any other information can be obtained during the full WHM determination. The form 94 is a part of the PE determination and must be completed at the same time as the 632w, it should be included in the PE WHM package and forwarded to the MRSM office. These documents are available in English and Spanish.

COMPLETION OF INDIVIDUAL ITEMS:

- | | |
|--|---|
| 1) Name, Address, and Date of Application: | Show exact name and address as on the Presumptive application. The date should be the same as the date the PE application is completed. |
| 2) Persons Requesting Medicaid: | Give information for all of the persons in the household for whom the applicant is requesting assistance. |
| 3) Persons Not Requesting Medicaid | Give information for all of the persons in the household for whom the applicant is not requesting assistance. |
| 4) Pregnant | List the name of the applicant, their due date, and the number of expected births. |
| 5) Income and Resource Questions: | Self-explanatory. Resources not counted in WHM. |
| 6) Childcare and Other Children Questions | Self-explanatory. |
| 7) Signatures: | The applicant and the person completing the form should sign the application. The form is not valid without a signature. |
| 8) Declaration of Citizenship | Above the signature line, if the first box is marked, and the applicant has noted on the front page that they are a U.S. Citizen then page three (3) is not required, nor is a separate form 216 (Revision 10/12 or later). |

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

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept.

- ☐ Pregnant Woman ☐ Women's Health
☐ Child under 19 ☐ Parent Caretaker
☐ Chafee Independence Program Medicaid
Where you in foster care on your 18th birthday? Yes No, in which state? _____

Check block(s) that apply to you:

PLEASE NOTE: A Face to Face interview is not required for Medicaid applications. Please answer all questions as completely and accurately as possible. If you cannot understand or complete this application, please notify DFCS staff and assistance will be provided free of charge.

Your Name: (Please Print) FIRST		M.I.	Last	Maiden (if applicable)	Today's Date:	
Mailing Address:					City:	State: Zip Code:
Residence Address (if different from Mailing Address):					Phone Number(s):	E-mail Address:

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

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Social Security Number	Is this Person a U.S. Citizen? (Y/N) (you may qualify for Medicaid even if you answer No)	Does the Father of this child live in your home? (Y/N)	Does the Mother of this child live in your home? (Y/N)

Please list all persons living with you for whom you DON'T want Medicaid. List yourself if you don't want Medicaid. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid. If provided, we will use the SSN for computer matches with other agencies and it may help us process your child's application. We will NOT share your information with the Department of Homeland Security (formerly the INS).

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

Are you pregnant? ☐ Yes ☐ No, Due Date: _____ Number expected _____. Are you able to have a baby? ☐ Yes ☐ No. Have you ever delivered a baby weighing less than 2500 grams (5 pounds, 8 ounces)? ☐ Yes ☐ No Have you delivered a baby weighing less than 1500 grams (3 pounds, 5 ounces) on or after January 1, 2011? ☐ Yes ☐ No. Do you have any unpaid medical bills from the past three months? ☐ Yes ☐ No If yes, which months? _____. Are you currently covered by other Health Insurance? Are you currently on Medicaid? ☐ Yes ☐ No If yes, list Insurance Company and policy number: _____. Does anyone in the household have any private health insurance? ☐ Yes ☐ No Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? ☐ Yes ☐ No If yes, have you received Women's Health Medicaid previously? ☐ Yes ☐ No

Form 94 (09/16)

INCOME, TAX FILER and DEPENDENT CARE

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

Income	Gross Amount per Pay Check (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving	Tax Filer Information
Wages/Earnings				1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ☐ Yes ☐ No If YES, who? (List each person who plans to file)
Current Employer:				2. Will any of the tax filers listed file jointly with a spouse? ☐ Yes ☐ No If YES, please list spouses name: _____
Wages/Earnings				3. Will any of the filers claim any dependents on their tax return? ☐ Yes ☐ No If YES, please list the names of dependents: _____
Current Employer:				4. Will anyone be claimed as a dependent on someone else's return? ☐ Yes ☐ No If YES, please list the name of the tax filer and the dependent: _____
Social Security Income/SSI				How is the tax dependent related to the tax filer? _____
Worker's Compensation				
Pensions or Retirement Benefits				
Child Support/Contributions				
Unemployment Benefits				
Other Income, please specify:				

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

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

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

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

I understand that this information may need to be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be obtained to verify and determine eligibility for Medicaid. I agree to assign to the state all rights to medical support and third party support payments (hospital and medical benefits). I agree to give the State the right to require an absent parent provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do not cooperate, I understand I may lose my Medicaid benefits, and only my children will receive benefits unless good cause is established. I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.

☐ I declare under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States. If I am a parent or legal guardian, I declare that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States. ☐ I declare to the best of my knowledge and belief that the person(s) for whom I am applying for Medicaid is/are U.S. citizen(s) or are lawfully present in the United States. I further certify under penalty of perjury that all of the information provided on this application is true and correct to the best of my knowledge.

Signature (Required): _____ Date: _____

Form 94 (09/16)

Vamos a considerar esta solicitud sin distinción de raza, color de piel, sexo, edad, discapacidad, religión, origen nacional o creencia política.

SOLICITUD DE MEDICAID

PARA USO EXCLUSIVO DEL CONDADO
Fecha de recibo en el Dpto. del Condado

Marque la(s) casilla(s) que correspondan:

- ☐ Mujer embarazada ☐ La salud de las mujeres
☐ Sólo niño(s) -19 RSM ☐ Familias con niños
☐ Medicaid del Programa Chafee Independence

Estuvo Ud. en cuidado de crianza (foster care) en su cumpleaños número 18? ☐ Sí ☐ No En cuál estado? _____

TOME EN CUENTA: Para las solicitudes de Medicaid, no es necesario una entrevista en persona. Por favor, conteste todas las preguntas de la manera más completa y exacta posible. Si no comprende o no puede completar esta solicitud, por favor, notifique al personal de DFCS y se le dará asistencia gratuita.

Su nombre: (En letra de molde) NOMBRE		I. Sdo. Nombre		Apellido		De soltera (si aplica)		Fecha de hoy:	
Dirección postal:				Ciudad:		Estado:		Código postal:	
Dirección de domicilio (si es distinta a la postal):				Número(s) de teléfono:		Correo electrónico:			

Escriba los nombres de todas las personas que viven con usted para quien usted quiere Medicaid. Escriba su nombre si desea Medicaid para usted.

Nombre	I. Sdo. Nombre	Apellido	Sufijo (Jr.)	Raza	Sexo M/F	Fecha de nacimiento	Parentesco con usted	Número de Seguro Social	Es esta persona ciudadano de EE.UU. (S/N) (pudiere calificar para Medicaid, incluso si responde No)	El padre de este niño vive en su casa? (S/N)	La madre de este niño vive en su casa? (S/N)

Escriba los nombres de todas las personas que viven con usted para quien usted NO quiere Medicaid. Escriba su nombre si no desea Medicaid para usted. Usted no tiene que proporcionar un número de Seguro Social ni información del estatus de inmigración de las personas que no están solicitando Medicaid. Si se proporciona, se utilizará el número de Seguro Social para que la computadora lo compare con otras agencias y puede ayudarnos a procesar la solicitud de su hijo. NO compartiremos su información con el Departamento de Seguridad Nacional (anteriormente el INS).

Nombre	I. Sdo. Nombre	Apellido	Sufijo (Jr.)	Raza	Sexo M/F	Fecha de nacimiento	Parentesco con usted	Número de Seguro Social	Es esta persona ciudadano de EE.UU. (S/N) (pudiere calificar para Medicaid, incluso si responde No)	El padre de este niño vive en su casa? (S/N)	La madre de este niño vive en su casa? (S/N)

Estas embarazada? ☐ Sí ☐ No Fecha de vencimiento: _____, Número de bebé? _____ Es capaz de tener un bebé? ☐ Sí ☐ No alguna vez ha entregado un bebé con un menos peso 2500 gramos (5 libras 8 onzas)? ☐ Sí ☐ No ha dado a luz un bebé con menos peso de 1500 gramos (3 libras y 5 onzas) después de 1 de enero del 2011? ☐ Sí ☐ No Tiene cuentas médicas pendientes de los últimos tres meses? ☐ Sí ☐ No Está actualmente cubierto por cualquier otro seguro de salud? ☐ Sí ☐ No se encuentra actualmente en Medicaid? ☐ Sí ☐ No Si es así, indique compañía de seguros y número de póliza: _____ Hay alguien en el hogar que tenga algún tipo de seguro de salud privado? ☐ Sí ☐ No

Form 94SP (09/16)

Usted o alguien en su hogar ha sido diagnosticado con cáncer de seno o de cuello uterino? ☐ Sí ☐ No En caso afirmativo, ha recibido Medicaid para Salud de la Mujer

INGRESOS, RECURSOS y GUARDERÍAS

Añote todos los ingresos que reciben las personas nombradas en la página 1 de esta solicitud. Asegúrese de mostrar la cantidad antes de las deducciones. Adjunte una hoja adicional si es necesario. Vamos a decidir, basándonos en el tipo de Medicaid, cuáles de esos ingresos deben ser contados y cuáles pueden excluirse. Si está solicitando Medicaid Sólo para Niños o para Embarazadas, usted no tiene que completar las siguientes secciones sobre recursos y vehículos.

Ingresos	Cantidad bruta por cheque de pago (Cantidad antes de deducciones)	¿Con qué frecuencia? (Semanal, cada dos semanas, mensual, etc?)	Nombre de la persona que los recibe	Impuestos Filer Estado
Salarios / ganancias				1. Tiene planes de presentar una declaración de impuestos federales el próximo año? (Todavía puede solicitar un seguro médico, incluso si usted no presenta una declaración de impuestos federales.) ☐ Sí En caso afirmativo, responda a las preguntas a-c ☐ No si no, pase a la pregunta c
Empleador actual:				2. Va a presentar conjuntamente con su cónyuge? ☐ Sí ☐ No En caso afirmativo, nombre del cónyuge: _____
Salarios / ganancias				3. Va a reclamar dependientes en su declaración de impuestos? ☐ Sí ☐ No En caso afirmativo lista de sus dependientes: _____
Empleador actual:				4. Va a ser reclamado como dependiente en la declaración de impuestos de otra cosa de alguien? ☐ Sí ☐ No En caso afirmativo, indique el nombre del archivero de impuestos: _____
Ingresos del Seguro Social / SSI				5. Cómo es su relación con el contribuyente de impuestos? Estas embarazada? ☐ Sí ☐ No en caso afirmativo, cuántos bebés se espera que durante este embarazo?
Compensación al Trabajador				
Pensiones o Beneficios de Jubilación				
Manutención de Menores/Contribuciones				
Beneficios de desempleo				
Otros ingresos, por favor, especifique:				

Paga por cuidado de dependientes (guardería para un niño o el cuidado de un adulto que no puede cuidar de sí mismo) para que alguien en su casa pueda trabajar?

Nombre del padre que trabaja	Nombre del niño o adulto que requiere el cuidado	Nombre del proveedor del cuidado	Monto del Pago	Con qué frecuencia? (Semanal, cada dos semanas, mensual, etc?)

Si usted está solicitando Medicaid para niños y uno o ambos padres del (los) niño(s) no están en la casa, suministre la siguiente información:

Nombre del niño	Nombre del padre ausente (Madre o padre)	Tienen ellos seguro médico para el niño? SI/No	Si tiene cobertura médica, anote el nombre de la compañía aseguradora y número de grupo

Entiendo que esta información quizá tenga que ser verificada para determinar la elegibilidad. Entiendo que quizá se obtenga información de sueldos y salarios proporcionada por el Departamento del Trabajo de Georgia para verificar y determinar la elegibilidad para Medicaid. Estoy de acuerdo en dar al Estado el derecho de exigir que un padre ausente proporcione seguro médico, si está disponible. Entiendo que tengo que conseguir la ayuda médica del padre ausente si la hay disponible y que tengo que cooperar con la División de Servicios de Manutención de Menores para obtener esta ayuda. Si yo no coopero, entiendo que puedo perder mis beneficios de Medicaid, y sólo mis hijos recibirán beneficios a menos que se establezca una buena causa. Entiendo que debo reportar cambios en mis ingresos y circunstancias dentro de los diez (10) días después de tener conocimiento del cambio.
☐ Declaro bajo pena de perjurio que soy un ciudadano de los EE. UU. o que estoy legalmente en los Estados Unidos. Si soy un padre o tutor legal, declaro que el (los) solicitante(s) es (son) ciudadano(s) de los EE. UU. o está(n) legalmente en los Estados Unidos. ☐ Declaro a mi leal saber y entender que la(s) persona(s) para las cuales estoy solicitando Medicaid es (son) ciudadano(s) de los EE. UU. o se encuentran en los Estados Unidos legalmente. Además, certifico bajo pena de perjurio que toda la información proporcionada en esta solicitud es verdadera y correcta según mi opinión.

Firma (Obligatoria): _____ Fecha: _____

Form 94SP (09/16)

DECLARACION DE CIUDADANIA/ESTADO MIGRATORIO

Departamento de Servicios Humanos de Georgia
División de Servicios para la Familia y los Niños

Entiendo que la División de Servicios para la Familia y los Niños (DFCS) del estado de Georgia puede requerir la verificación del Departamento de Seguridad Nacional (DHS) de la ciudadanía de mi/mis hijos o su estado migratorio al solicitar los beneficios. La información que se reciba del DHS puede afectar la elegibilidad mi/mis hijos.

Por favor llene y firme UNA o AMBAS declaraciones en lo que respecta al estado de cada una de las personas que solicitan beneficios.

NINOS QUE SOLICITAN BENEFICIOS

Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano de EE.UU.	Admitido al país legalmente como inmigrante (marque lo que corresponda)	Fecha de naturalización o admisión a los EE.UU. (si corresponde)	Número de identificación de documento migratorio (si corresponde)
					A-
					A-
					A-
					A-
					A-

Yo _____ doy fe que la identidad del(los) niño(niños) identificados arriba
(NOMBRE EN LETRA DE IMPRIMENTA)
y certifico bajo pena de perjurio que la información escrita y marcada arriba es verdadera.

FIRMA

FECHA

ADULTO(S) QUE SOLICITAN BENEFICIOS

Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano de EE.UU.	Admitido al país legalmente como inmigrante (marque lo que corresponda)	Fecha de naturalización o admisión a los EE.UU. (si corresponde)	Número de identificación de documento migratorio (si corresponde)
					A-
					A-

Yo _____ doy fe de la identidad del(los) adulto(s) identificados arriba y
(NOMBRE EN LETRA DE IMPRIMENTA)
certifico bajo pena de perjurio que la información escrita y marcada arriba es verdadera

FIRMA

FECHA

NOTICE OF ACTION Form DMA 634W:

634W Approval

This form is used to provide notice to the applicant when a PE determination is approved, and the temporary Medical Assistance certificate was not printed. It is to be given to the member at the time of her PE approval. A copy of this form will be included in the PE packet given to MRSM.

634W 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 she is determined not eligible. A copy of this form will be included in the PE packet given to MRSM.

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, she is not eligible. The reason for denial will be one or more of the reasons below:

- she does not meet the BCCP requirements
- her income exceeds the income standard
- she is 65 years of age or older
- she does not meet the citizenship/qualified immigrant status requirements
- she is not a GA resident
- she has private major medical insurance
- she receives Medicare

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.



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

NOTICE OF ACTION

Presumptive Eligibility for Women's Health Medicaid

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

☐ **PRESUMPTIVE ELIGIBILITY APPROVED:** _____
Medicaid ID Number _____

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

When you applied for PE Women's Health Medicaid, you may also have applied for ongoing/retroactive Medicaid. Your Medicaid application will be sent to MORROW Right from the Start Medical (MRSM) Assistance Group. MRSM will make the decision for your regular Medicaid benefits and notify you by mail.

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

Signature of Qualified Provider _____ Qualified Provider Address _____

Title _____ Phone Number _____ Qualified Provider ID Number _____

DMA 63HW (Approval) Revised 03/01/19

Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan | Health Planning

Equal Opportunity Employer



Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

NOTICE OF ACTION

Presumptive Eligibility for Women's Health Medicaid

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

☐ PRESUMPTIVE ELIGIBILITY DENIED

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

The reason for denial is: Choose an item.

When you applied for PE Women's Health Medicaid, you may also have applied for ongoing/retroactive Medicaid. Your Medicaid application will be sent to MORROW Right from the Start Medical (MRSM) Assistance Group. MRSM will make the decision for your regular Medicaid benefits and notify you by mail. MRSM may determine you are potentially eligible for another type of Medicaid and will notify you. If you are not eligible for Medicaid, your Medicaid application will be referred to the Federally Facilitated Marketplace (FFM) for consideration. You will be notified directly by the FFM.

You may find additional FFM information, or apply directly for Healthcare coverage at www.healthcare.gov, or you may call the FFM anytime at 1-800-318-2596, TTY 1-855-889-4325.

Signature of Qualified Provider _____ Qualified Provider Address _____
Title _____ Phone Number _____ Qualified Provider ID Number _____

DMA 634W (Denial) Revised 02/01/19

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

Equal Opportunity Employer

CERTIFICATION OF DIAGNOSIS

Revised
03/18/19



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

Women's Health Medical Assistance Program

Certification of Diagnosis

Client Name: _____

Client SS #: _____
(optional)

Clinic Name: _____

Diagnosis (Biopsy) Date: _____

Diagnosis: _____

Physician's Signature: _____ Date: _____

INSTRUCTIONS:

Please attach a copy of the **PATHOLOGY REPORT** confirming this diagnosis.

Purpose of this form – This form is required to refer women to the Women's Health Medical Assistance Program for treatment of breast or cervical cancer/pre-cancer.

Completion of this form – The physician or an authorized licensed medical professional of the physician (i.e., LPN, RN, NP or PA) designated to sign on behalf of the physician must complete this form and send it with the client to the Health Department or other Qualified Georgia Breast & Cervical Cancer Program Providers for Presumptive Eligibility (PE) determination. The Breast and Cervical Cancer Program Provider should place a copy of this form in the client's record.

Revised 03/11/19

Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan | Health Planning

Equal Opportunity Employer

**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 member agrees to assign their rights to payments from TPL to DCH.

TPL available to the member must be used by DCH to reduce or recover Medical Assistance payments for medical services. Resources include group, private, or HMO health insurance policies held by the member, member'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 member's file. A separate DMA 285 should be prepared and sent to 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 photocopy in the file.

If no TPL is 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 canceled, 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 HMS.

EXAMPLE OF FORM DMA 285 COMPLETED:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH - THIRD PARTY LIABILITY HEALTH INSURANCE INFORMATION QUESTIONNAIRE																																																																																		
CASE NAME: <u>Applicant's Name</u>			CASE NO: <u>N/A (for PE)</u>																																																																															
ADDRESS: <u>Applicant's mailing</u>			SSN: <u>123-45-6789</u>																																																																															
<u>Address</u>			PHONE NO: <u>Day time phone number</u>																																																																															
TYPE OF CASE: ☒ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION (Check all that apply) ☐ HIPP REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION: <u>01/01/XX</u>																																																																																		
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 C.F.R. 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)			☐ YES ☒ 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?			☒ YES ☐ NO																																																																															
Is policyholder an Absent Parent?			☐ YES ☒ NO																																																																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">Names of Covered Individuals in Household</th> <th>Medicaid ID#</th> <th>SSN</th> <th colspan="5">Relationship to Policy Holder (check one)</th> <th>Date Of Birth</th> </tr> <tr> <th>(Last)</th> <th>(First)</th> <th>(MI)</th> <th></th> <th></th> <th>Policy Holder</th> <th>Spouse</th> <th>Child</th> <th>Step-child</th> <th>Other</th> <th></th> </tr> </thead> <tbody> <tr> <td>Member</td> <td>Georgia</td> <td></td> <td>111223456789</td> <td>123-45-6789</td> <td></td> <td></td> <td></td> <td></td> <td>X</td> <td>2/11/70</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>						Names of Covered Individuals in Household			Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth	(Last)	(First)	(MI)			Policy Holder	Spouse	Child	Step-child	Other		Member	Georgia		111223456789	123-45-6789					X	2/11/70																																												
Names of Covered Individuals in Household			Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth																																																																								
(Last)	(First)	(MI)			Policy Holder	Spouse	Child	Step-child	Other																																																																									
Member	Georgia		111223456789	123-45-6789					X	2/11/70																																																																								
Are any of these persons pregnant? ☒ YES ☐ NO If yes, Name <u>Georgia Member</u> Date of Delivery <u>5/22/xx</u>																																																																																		
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 _____																																																																																
<table style="width: 100%;"> <tr> <td colspan="2">BCBS</td> <td colspan="4" style="text-align: right;">(800) 331-BCBS</td> </tr> <tr> <td colspan="2">(Insurance Company Name)</td> <td colspan="4">(Telephone Number)</td> </tr> <tr> <td colspan="2"><u>2 Peachtree Street</u></td> <td><u>Columbus</u></td> <td><u>GA</u></td> <td colspan="2"><u>31392</u></td> </tr> <tr> <td colspan="2">(Address)</td> <td>(City)</td> <td>(State)</td> <td colspan="2">(Zip)</td> </tr> <tr> <td colspan="2"><u>Mr. X Husband Member</u></td> <td><u>987-65-4321</u></td> <td><u>ABC123</u></td> <td colspan="2"><u>04/19/65</u></td> </tr> <tr> <td colspan="2">(Policyholder Name)</td> <td>(Policyholder SSN)</td> <td>(Policy Number)</td> <td colspan="2">(Policyholder DOB)</td> </tr> <tr> <td colspan="2"><u>12/31/00</u></td> <td colspan="4"></td> </tr> <tr> <td colspan="2">(Policy Effective Date)</td> <td colspan="4">(Policy Termination Date)</td> </tr> <tr> <td colspan="2"><u>ABC Construction</u></td> <td colspan="4"><u>706-321-5555</u></td> </tr> <tr> <td colspan="2">(Employer Name)</td> <td colspan="4">(Telephone Number)</td> </tr> <tr> <td colspan="2"><u>211 Maple Drive</u></td> <td><u>LaGrange</u></td> <td><u>GA</u></td> <td colspan="2"><u>34567</u></td> </tr> <tr> <td colspan="2">(Employer Address)</td> <td>(City)</td> <td>(State)</td> <td colspan="2">(Zip)</td> </tr> </table>						BCBS		(800) 331-BCBS				(Insurance Company Name)		(Telephone Number)				<u>2 Peachtree Street</u>		<u>Columbus</u>	<u>GA</u>	<u>31392</u>		(Address)		(City)	(State)	(Zip)		<u>Mr. X Husband Member</u>		<u>987-65-4321</u>	<u>ABC123</u>	<u>04/19/65</u>		(Policyholder Name)		(Policyholder SSN)	(Policy Number)	(Policyholder DOB)		<u>12/31/00</u>						(Policy Effective Date)		(Policy Termination Date)				<u>ABC Construction</u>		<u>706-321-5555</u>				(Employer Name)		(Telephone Number)				<u>211 Maple Drive</u>		<u>LaGrange</u>	<u>GA</u>	<u>34567</u>		(Employer Address)		(City)	(State)	(Zip)						
BCBS		(800) 331-BCBS																																																																																
(Insurance Company Name)		(Telephone Number)																																																																																
<u>2 Peachtree Street</u>		<u>Columbus</u>	<u>GA</u>	<u>31392</u>																																																																														
(Address)		(City)	(State)	(Zip)																																																																														
<u>Mr. X Husband Member</u>		<u>987-65-4321</u>	<u>ABC123</u>	<u>04/19/65</u>																																																																														
(Policyholder Name)		(Policyholder SSN)	(Policy Number)	(Policyholder DOB)																																																																														
<u>12/31/00</u>																																																																																		
(Policy Effective Date)		(Policy Termination Date)																																																																																
<u>ABC Construction</u>		<u>706-321-5555</u>																																																																																
(Employer Name)		(Telephone Number)																																																																																
<u>211 Maple Drive</u>		<u>LaGrange</u>	<u>GA</u>	<u>34567</u>																																																																														
(Employer Address)		(City)	(State)	(Zip)																																																																														
<table style="width: 100%;"> <tr> <td colspan="3"> Types of Coverage (circle those which apply) <table style="width: 100%;"> <tr> <td>01 - HOSPITAL INPT.</td> <td>15 - LTCNH</td> </tr> <tr> <td>07 - DRUGS/STD</td> <td>16 - HMO/DRUG</td> </tr> <tr> <td>08 - MAJOR MED.</td> <td>17 - MED. SUPP A</td> </tr> <tr> <td>09 - DENTAL</td> <td>18 - MED. SUPP B</td> </tr> <tr> <td>10 - VISION</td> <td>22 - HMO/STD</td> </tr> <tr> <td colspan="2">OTHER _____</td> </tr> </table> </td> <td colspan="3"></td> </tr> </table>						Types of Coverage (circle those which apply) <table style="width: 100%;"> <tr> <td>01 - HOSPITAL INPT.</td> <td>15 - LTCNH</td> </tr> <tr> <td>07 - DRUGS/STD</td> <td>16 - HMO/DRUG</td> </tr> <tr> <td>08 - MAJOR MED.</td> <td>17 - MED. SUPP A</td> </tr> <tr> <td>09 - DENTAL</td> <td>18 - MED. SUPP B</td> </tr> <tr> <td>10 - VISION</td> <td>22 - HMO/STD</td> </tr> <tr> <td colspan="2">OTHER _____</td> </tr> </table>			01 - HOSPITAL INPT.	15 - LTCNH	07 - DRUGS/STD	16 - HMO/DRUG	08 - MAJOR MED.	17 - MED. SUPP A	09 - DENTAL	18 - MED. SUPP B	10 - VISION	22 - HMO/STD	OTHER _____																																																															
Types of Coverage (circle those which apply) <table style="width: 100%;"> <tr> <td>01 - HOSPITAL INPT.</td> <td>15 - LTCNH</td> </tr> <tr> <td>07 - DRUGS/STD</td> <td>16 - HMO/DRUG</td> </tr> <tr> <td>08 - MAJOR MED.</td> <td>17 - MED. SUPP A</td> </tr> <tr> <td>09 - DENTAL</td> <td>18 - MED. SUPP B</td> </tr> <tr> <td>10 - VISION</td> <td>22 - HMO/STD</td> </tr> <tr> <td colspan="2">OTHER _____</td> </tr> </table>			01 - HOSPITAL INPT.	15 - LTCNH	07 - DRUGS/STD	16 - HMO/DRUG	08 - MAJOR MED.	17 - MED. SUPP A	09 - DENTAL	18 - MED. SUPP B	10 - VISION	22 - HMO/STD	OTHER _____																																																																					
01 - HOSPITAL INPT.	15 - LTCNH																																																																																	
07 - DRUGS/STD	16 - HMO/DRUG																																																																																	
08 - MAJOR MED.	17 - MED. SUPP A																																																																																	
09 - DENTAL	18 - MED. SUPP B																																																																																	
10 - VISION	22 - HMO/STD																																																																																	
OTHER _____																																																																																		
<table style="width: 100%;"> <tr> <td colspan="3"> 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. </td> <td colspan="3"> 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. </td> </tr> <tr> <td colspan="3"> Applicant's Signature _____ Date <u>01/01/xx</u> </td> <td colspan="3"> Applicant's Signature _____ Date <u>01/01/xx</u> </td> </tr> <tr> <td colspan="3"> Member or Authorized Person </td> <td colspan="3"> Insured or Authorized Person </td> </tr> </table>						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.			Applicant's Signature _____ Date <u>01/01/xx</u>			Applicant's Signature _____ Date <u>01/01/xx</u>			Member or Authorized Person			Insured or Authorized Person																																																													
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.																																																																															
Applicant's Signature _____ Date <u>01/01/xx</u>			Applicant's Signature _____ Date <u>01/01/xx</u>																																																																															
Member or Authorized Person			Insured or Authorized Person																																																																															
EFFECTIVE DATE OF MEDICAID ELIGIBILITY <u>01/01/xx</u>																																																																																		
Case Worker Name: <u>Qualified Provider Worker</u> Phone No: <u>Direct Phone</u> County: _____																																																																																		
DMA-285-REV. (01/00)																																																																																		

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

Declaration of Citizenship/Immigration Status:

This form is completed by the applicant to self-declare citizenship/legal immigration status. A copy should be retained in the case file and a copy sent to the Morrow (MRSM) office as part of the PE packet.

This is page 3 of the 94 Medical Assistance application.

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-
					A-
					A-
					A-
					A-
I, _____ attest to the best of my knowledge to the identity of the child/children (PRINT NAME) listed above and certify under penalty of perjury, that the information written and checked above is true. _____ SIGNATURE _____ (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, _____ attest to the best of my knowledge to the identity of the adult(s) listed (PRINT NAME) above and certify under penalty of perjury, that the information written and checked above is true. _____ SIGNATURE _____ (DATE)					
Form 216 ENG-SP Rev. 09/18					

DECLARACION DE CIUDADANIA/ESTADO MIGRATORIO

Departamento de Servicios Humanos de Georgia
División de Servicios para la Familia y los Niños

Entiendo que la División de Servicios para la Familia y los Niños (DFCS) del estado de Georgia puede requerir la verificación del Departamento de Seguridad Nacional (DHS) de la ciudadanía de mi/mis hijos o su estado migratorio al solicitar los beneficios. La información que se reciba del DHS puede afectar la elegibilidad mi/mis hijos.

Por favor llene y firme UNA o AMBAS declaraciones en lo que respecta al estado de cada una de las personas que solicitan beneficios.

NINOS QUE SOLICITAN BENEFICIOS

Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano de EE.UU.	Admitido al país legalmente como inmigrante (marque lo que corresponda)	Fecha de naturalización o admisión a los EE.UU. (si corresponde)	Número de identificación de documento migratorio (si corresponde)
					A-
					A-
					A-
					A-
					A-

Yo _____ doy fe que la identidad del(los) niño(niños) identificados arriba
(NOMBRE EN LETRA DE IMPRIMENTA)
y certifico bajo pena de perjurio que la información escrita y marcada arriba es verdadera.

FIRMA

FECHA

ADULTO(S) QUE SOLICITAN BENEFICIOS

Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano de EE.UU.	Admitido al país legalmente como inmigrante (marque lo que corresponda)	Fecha de naturalización o admisión a los EE.UU. (si corresponde)	Número de identificación de documento migratorio (si corresponde)
					A-
					A-

Yo _____ doy fe de la identidad del(los) adulto(s) identificados arriba y
(NOMBRE EN LETRA DE IMPRIMENTA)
certifico bajo pena de perjurio que la información escrita y marcada arriba es verdadera.

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 healthcare in the United States by restoring trust in the health care system among consumers, healthcare professionals and the many organizations and individuals committed to the delivery of healthcare; and
- To improve the efficiency and effectiveness of healthcare 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 of the PE application is approved or denied. Since all PE applications will go to the MRSM office, 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 MRSM office 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 maintains your PHI at telephone (229) 337 - 7449 , facsimile (229) 377 - 3277 , or by mail to:

MORROW Right from the Start Medical Assistance Group Project

Team

Attention: Jamie M. Anderson

800 North Broad Street

Cairo, GA 39828

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

Signature

APPLICANT'S MAILING ADDRESS HERE

Mailing Address

APPLICANT'S PRINTED NAME

(Please print name)

Date

City, State, Zip

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

QP/QH COUNTY HERE

County Office

QP/QH NAME HERE

Case Manager

N/A

Load #

QP/QH MAILING ADDRESS HERE

Mailing Address

City, State, Zip

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

Date: April 8, 2016

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.

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 disclosed 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 have any questions about this notice, please contact:

Georgia Department of Human Services
HIPAA Privacy Officer
2 Peachtree Street, NW Suite 29-210
Atlanta GA 30303-3142
HIPAADHS@dhs.ga.gov

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

Notificación de prácticas de privacidad de HIPAA Departamento de Servicios Humanos de Georgia

Fecha: 8 de abril de 2016

ESTA NOTIFICACIÓN DESCRIBE CÓMO SE PODRÍA USAR Y DIVULGAR SU INFORMACIÓN MÉDICA Y CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN.

REVISE ESTA NOTIFICACIÓN CUIDADOSAMENTE.

El Departamento de Servicios Humanos (DHS) es una agencia de la Rama Ejecutiva del gobierno de Georgia a cargo de administrar numerosos programas federales responsables de guardar, usar y mantener la información médica y otra información confidencial. Las leyes federales y estatales establecen requisitos estrictos para estos programas en relación con el uso y la divulgación de información protegida y confidencial. DHS está obligado a cumplir con estas leyes como se declara en esta notificación.

OBLIGACIONES DEL DEPARTAMENTO DE SERVICIOS HUMANOS:

A DHS se le requiere por ley:

- Mantener la confidencialidad de la información protegida de salud;
- Entregarle esta notificación de nuestras obligaciones y prácticas de privacidad con referencia a la información médica de usted; y
- Cumplir con los términos de la notificación que está en efecto actualmente.

CÓMO PUEDE DHS USAR Y DIVULGAR SU INFORMACIÓN MÉDICA:

Las siguientes categorías describen diferentes maneras en las que DHS usa y divulga información médica que lo identifica a usted ("Información de Salud"). Con excepción de los propósitos descritos a continuación, DHS usará y divulgará su Información de Salud solamente con su consentimiento por escrito. Usted puede revocar tal permiso en cualquier momento mediante una carta al HIPAA Privacy Officer (Funcionario de Privacidad de HIPAA) en la dirección de contacto indicada anteriormente.

Para tratamiento. DHS puede usar y divulgar su Información de Salud para proporcionarle tratamiento médico o servicios de cuidado relacionados con el tratamiento. Por ejemplo, DHS puede divulgar su Información de Salud a médicos, enfermeros, técnicos u otro personal que participe en su cuidado médico y necesite información para proporcionarle cuidado médico.

Para pago. DHS puede usar y divulgar su Información de Salud para que DHS u otros puedan facturar y recibir pagos relacionados con su cuidado, una compañía de seguro o terceros por el tratamiento y servicios que usted haya recibido. Por ejemplo, DHS podría dar la información a su plan de salud para que su tratamiento sea pagado.

Para propósitos de cuidado de salud. DHS puede usar y divulgar Información de Salud para propósitos de cuidado de la salud. Estos usos y divulgaciones son necesarios para asegurarnos de

que usted reciba cuidados de calidad y para operar, dirigir y administrar las funciones de la agencia. Por ejemplo, DHS puede usar y divulgar información para asegurarse de que los cuidados médicos que usted recibe son de calidad superior. DHS también puede compartir información con otras entidades con las cuales usted tiene una relación (por ejemplo, su plan de salud) para propósitos de cuidado de la salud.

Recordatorios de citas, alternativas de tratamiento y beneficios y servicios relacionados con la salud. DHS puede usar y divulgar Información de Salud para comunicarse con usted con el propósito de recordarle su cita con un médico. DHS también puede usar y divulgar Información de Salud para hablarle de las alternativas de tratamiento o de los beneficios y servicios relacionados con la salud que le puedan interesar.

Personas que participan en su cuidado o pagan por su cuidado. Cuando sea adecuado, DHS puede compartir su Información de Salud con una persona que participa en su cuidado médico o paga por su cuidado, como su familia o un amigo cercano. DHS también puede notificar a su familia sobre su ubicación o condición general o divulgar tal información a una entidad que ayude con esfuerzos de socorro en casos de desastre.

Investigación. Bajo ciertas circunstancias, DHS puede usar y divulgar Información de Salud para investigación. Por ejemplo, un proyecto investigativo podría comparar la salud de pacientes que reciben un tratamiento con la de aquellos que reciben otro tratamiento para la misma condición de salud. Antes de que DHS use o divulgue Información de Salud para investigación, el proyecto pasará por un proceso especial de aprobación. Aun sin la aprobación especial, DHS podrá permitir a los investigadores ver los expedientes con el propósito de ayudarlos a identificar a pacientes que podrían ser incluidos en el proyecto investigativo o con propósitos similares, siempre y cuando no saquen o hagan una copia de cualquier Información de Salud.

SITUACIONES ESPECIALES:

Según lo requiera la ley. DHS divulgará Información de Salud cuando sea requerido por las leyes internacionales, federales, estatales o locales.

Para evitar una amenaza seria contra la salud o la seguridad. DHS puede usar y divulgar Información de Salud sobre usted cuando sea necesario para evitar una amenaza seria contra su salud y seguridad o la salud y seguridad del público u otra persona. Solamente se divulgará a alguien que pueda ayudar a evitar la amenaza.

Asociados comerciales. DHS puede divulgar Información de Salud a nuestros asociados comerciales que desempeñan funciones en nombre nuestro o nos proporcionan sus servicios, si dicha información fuera necesaria para dichas funciones o servicios. Por ejemplo, DHS podrá utilizar los servicios de una entidad diferente para desempeñar servicios de cobro. Todos los asociados comerciales de DHS están obligados a proteger la información de privacidad y no tienen permiso para usar o divulgar ninguna otra información que no esté especificada en nuestro contrato.

Donación de órganos y tejidos. Si usted es donante de órganos, DHS puede usar o hacer pública Información de Salud a organizaciones que se encargan del manejo de órganos u otras entidades dedicadas a la obtención, el almacenamiento o el transporte de órganos, ojos o tejidos, con el fin de facilitar la donación y el trasplante de estos.

Militares y veteranos. Si usted es miembro de las fuerzas armadas, DHS puede hacer pública la Información de Salud como sea requerido por las autoridades del comando militar. DHS puede también divulgar Información de Salud a las autoridades militares adecuadas en el extranjero, si usted es miembro de las fuerzas armadas extranjeras.

Compensación laboral. DHS puede hacer pública Información de Salud para Compensación a los Trabajadores o programas similares. Estos programas proporcionan beneficios para lesiones o enfermedades relacionadas con el trabajo.

Riesgos a la salud pública. DHS puede divulgar Información de Salud para actividades de salud pública. Estas actividades generalmente incluyen divulgaciones para evitar o controlar enfermedades, lesiones o discapacidades; reportar nacimientos y muertes; reportar abuso o negligencia infantil; reportar reacciones a medicamentos o problemas con productos; notificar a las personas acerca del retiro de productos que puedan estar usando; una persona que pueda haber estado expuesta a una enfermedad o pueda estar a riesgo de contraer o propagar una enfermedad o afección; y a la autoridad gubernamental adecuada si se cree que un paciente ha sido víctima de abuso, negligencia o violencia doméstica. DHS solamente divulgará esto si usted está de acuerdo o si la ley así lo exige o lo autoriza.

Actividades de supervisión de salud. DHS puede divulgar su Información de Salud a una agencia supervisora de actividades de salud que la ley autorice. Estas actividades de supervisión incluyen, por ejemplo, auditorías, investigaciones, inspecciones y acreditación. Estas actividades son necesarias para que el gobierno vigile el sistema de cuidado de la salud, los programas gubernamentales y el cumplimiento de las leyes de derechos civiles.

Fines de notificación cuando hay filtración de información. DHS puede usar o divulgar su Información de Salud para proporcionar notificaciones requeridas por la ley en caso de acceso o divulgación de su Información de Salud sin su autorización.

Demandas y disputas. Si usted es parte de una demanda o una disputa, DHS puede divulgar su Información de Salud en respuesta a un mandato judicial o administrativo. DHS también puede divulgar Información de salud en respuesta a una citación, solicitud de revelación de pruebas u otro proceso legal por otra persona que sea parte de la disputa, siempre y cuando se hayan tomado las medidas necesarias para avisarle de la solicitud o para obtener una orden de protección de la información solicitada.

En cumplimiento de la ley. DHS puede revelar su Información de Salud si se la solicita un funcionario del orden público, si la información es: (1) en respuesta a una orden del tribunal, citación judicial, emplazamiento o un proceso similar; (2) información limitada para identificar o ubicar a un sospechoso, fugitivo, testigo material o persona desaparecida; (3) sobre la víctima de un delito aun si, bajo ciertas circunstancias limitadas, no podamos obtener la autorización de dicha persona; (4) sobre una muerte que creamos que sea el resultado de una conducta criminal; (5) sobre una conducta criminal en nuestros predios; y (6) en caso de una emergencia para informar un delito, la ubicación del delito o las víctimas, o la identidad, descripción o ubicación de la persona que cometió el delito.

Médicos forenses, examinadores médicos y directores de funerarias. DHS puede revelar su Información de Salud a un médico forense o a un examinador médico. Esto puede ser necesario, por ejemplo, para identificar a una persona fallecida o determinar la causa de la muerte. DHS

también puede revelar Información de Salud a directores de funerarias si fuera necesario para el cumplimiento de sus deberes.

Actividades de inteligencia y seguridad nacional. DHS puede divulgar Información de Salud a funcionarios federales autorizados para actividades de inteligencia, contrainteligencia y otras actividades de seguridad nacional autorizadas por ley.

Servicios de protección para el Presidente de EE.UU. y otros. DHS puede divulgar Información de Salud a funcionarios federales autorizados para que puedan proporcionar protección al presidente, otras personas autorizadas o jefes de Estado extranjeros o para realizar investigaciones especiales.

Presos o personas bajo custodia. Si usted está preso en una institución penal o está bajo la custodia de un funcionario del orden público, DHS puede revelar su Información de Salud a la institución penal o al funcionario del orden público. Esto será necesario: (1) para que la institución le brinde atención médica, (2) para proteger su salud y seguridad o la salud y seguridad de los demás, o (3) para la seguridad de la institución correccional.

USOS Y DIVULGACIONES QUE LE EXIGEN A DHS DARLE A USTED UNA OPORTUNIDAD PARA OBJETAR Y OPTAR

Personas que participan en su cuidado o pagan por su cuidado. A menos que usted se oponga, DHS puede divulgar a un miembro de su familia, a un pariente, a un amigo cercano o a cualquier otra persona que usted designe, la parte de su Información Protegida de Salud que se relacione directamente con la participación de dicha persona en el cuidado de su salud. Si usted no puede aceptar u objetar dicha divulgación, DHS puede divulgar dicha información si lo considera necesario para su bienestar, basado en el criterio profesional de DHS.

Socorro en casos de desastre. DHS puede divulgar su Información Protegida de Salud a organizaciones de socorro en casos de desastre que busquen su Información Protegida de Salud para coordinar su cuidado, o notificar a su familia o amigos sobre su ubicación o condición en un desastre. DHS le dará la oportunidad de aprobar u objetar dicha divulgación cuando sea práctico hacerlo.

SE REQUIERE SU AUTORIZACIÓN POR ESCRITO PARA OTROS USOS Y DIVULGACIONES

Los siguientes usos y divulgaciones de su Información Protegida de Salud se harán únicamente con su autorización por escrito:

1. Usos y divulgaciones de su Información Protegida de Salud para propósitos de mercadeo; y,
2. Divulgaciones que constituyen una venta de su Información Protegida de Salud.

Otros usos y divulgaciones de su Información Protegida de Salud que no estén cubiertos bajo esta notificación o bajo las leyes que regulan a DHS, solo se harán con la autorización de usted por escrito. Si usted, en efecto, proporciona una autorización a DHS, usted puede anularla en cualquier momento, mediante la presentación de una anulación por escrito al Funcionario de Privacidad mencionado anteriormente. Una vez recibida la petición, DHS no divulgará más su

Información Protegida de Salud bajo la autorización. Sin embargo, las divulgaciones que se hagan de acuerdo con su autorización antes de que usted la anule, no se verán afectadas por su anulación.

SUS DERECHOS:

Usted tiene los siguientes derechos con referencia a la Información de Salud que DHS guarda sobre usted:

Derecho de inspeccionar y recibir copias. Usted tiene el derecho de inspeccionar y recibir copias de la Información de Salud que podría ser utilizada para pagos o para tomar decisiones sobre su cuidado. Esto incluye los registros médicos y de facturas que no sean notas de psicoterapia. Para inspeccionar y recibir copias de Información de Salud, usted debe presentar su pedido por escrito al Funcionario de Privacidad de HIPAA mencionado anteriormente. DHS tiene hasta 30 días para poner a su disposición la información protegida de salud y puede cobrarle una cantidad razonable por los costos de copiar, enviar por correo u otros materiales relacionados con su pedido. DHS no puede cobrarle si usted necesita la información para hacer una reclamación de beneficios según la Ley del Seguro Social o de cualquier otro beneficio estatal o federal basado en la necesidad. DHS puede denegar su petición en ciertas circunstancias limitadas. Si DHS, en efecto, le deniega su petición, usted tiene el derecho de solicitar que la denegación sea revisada por un profesional de atención de la salud licenciado que no haya participado directamente en la denegación de su petición, y DHS cumplirá con el resultado de la revisión.

Derecho a una copia electrónica de registros médicos electrónicos. Si su Información Protegida de Salud es mantenida en un formato electrónico (conocido como un registro médico electrónico o un registro electrónico de salud), usted tiene derecho a pedir que se le entregue una copia electrónica de su registro o que sea transmitida a otra persona o entidad. DHS hará todo lo posible para proporcionar acceso a su Información Protegida de Salud en la forma o formato que usted solicite, si la información es fácil de reproducir en dicha forma o formato. Si la Información Protegida de Salud no es fácil de reproducir en la forma o formato que usted solicite, se le proporcionará su registro en alguno de nuestros formatos electrónicos estándar. Si usted no quiere esta forma o formato, recibirá una copia legible impresa. DHS puede cobrarle un cargo razonable, basado en el costo del trabajo asociado con la transmisión del registro médico electrónico.

Derecho a recibir una notificación cuando se produce una infracción con respecto a su información. Usted tiene derecho a recibir una notificación si se produce una infracción con respecto a su Información Protegida de Salud no segura.

Derecho de enmienda. Si usted cree que la Información de Salud que tenemos sobre usted es incorrecta o está incompleta, puede solicitar que DHS enmiende la información. Usted tiene derecho a pedir una enmienda mientras la información se mantenga en, o para nuestra oficina. Para pedir una enmienda, debe presentar su solicitud por escrito al Funcionario de Privacidad de HIPAA mencionado anteriormente.

Derecho a una lista de divulgaciones. Usted tiene derecho a pedir una lista de ciertas divulgaciones de Información de Salud que DHS haya hecho para propósitos ajenos a los tratamientos, pagos y operaciones de atención médica, o para los cuales usted haya proporcionado una autorización por escrito. Para pedir una lista de las divulgaciones, debe presentar su solicitud por escrito al Funcionario de Privacidad de HIPAA mencionado anteriormente.

Derecho a solicitar restricciones. Usted tiene derecho a solicitar restricciones o limitaciones en la Información de Salud que DHS usa o divulga sobre usted para tratamiento, pago o cuidado de la salud. Usted también tiene derecho a solicitar un límite en la información médica que nosotros divulguemos sobre usted a alguien que participe en su cuidado o el pago por su cuidado, como un miembro de su familia o un amigo. Por ejemplo, usted puede pedir que DHS no comparta información sobre un diagnóstico o tratamiento en particular con su cónyuge. Para pedir una restricción, usted debe hacer una petición por escrito al Funcionario de Privacidad HIPAA mencionado anteriormente. DHS no está obligado a aceptar su solicitud, a menos que usted esté solicitando a DHS restringir el uso y la divulgación de su Información Protegida de Salud a un plan de salud para propósitos de pago o actividades relacionadas con el cuidado de su salud y la información que desea restringir se refiera exclusivamente a un artículo de cuidado de la salud o un servicio por el cual usted pagó en su totalidad con su propio dinero. Si DHS está de acuerdo, cumpliremos con su pedido, a menos que la información sea necesaria para proporcionarle un tratamiento de emergencia.

Derecho a solicitar comunicaciones confidenciales. Usted tiene derecho a solicitar que DHS se comunique con usted sobre asuntos médicos de cierta manera o en cierto lugar. Por ejemplo, puede pedir que DHS solamente lo contacte por correo o en su trabajo. Para solicitar comunicaciones confidenciales, usted debe presentar una solicitud por escrito al Funcionario de Privacidad de HIPAA mencionado anteriormente. Su solicitud debe especificar cómo o dónde usted desea ser contactado. DHS atenderá las solicitudes razonables.

Derecho a una copia en papel de esta notificación. Usted tiene derecho a recibir una copia en papel de esta notificación. Usted puede solicitar una copia de esta notificación en cualquier momento. Aunque usted haya aceptado recibir esta notificación electrónicamente, usted todavía tiene derecho a recibir una copia en papel. Para obtener una copia en papel de esta notificación, comuníquese con el Funcionario de Privacidad de HIPAA mencionado anteriormente.

CAMBIOS A ESTA NOTIFICACIÓN:

DHS se reserva el derecho de cambiar esta notificación y hacer que la nueva notificación aplique a la Información de Salud que ya tenemos sobre usted, así como también a cualquier información que recibamos en el futuro. DHS publicará una copia de la notificación actual en nuestras oficinas. La notificación contendrá la fecha de entrada en vigor en la primera página, en la esquina superior derecha.

QUEJAS:

Si tiene alguna pregunta relacionada con esta notificación, comuníquese con:

Georgia Department of Human Services
Funcionario de Privacidad de HIPAA
2 Peachtree Street, NW Suite 29-210
Atlanta GA 30303-3142
HIPAADHS@dhs.ga.gov

Si usted cree que se han violado sus derechos de privacidad, puede presentar una queja por escrito al Funcionario de Privacidad de HIPAA mencionado anteriormente. **Usted no será sancionado por presentar una queja.**

Usted también puede presentar una queja ante el Secretario del Departamento de Salud y Servicios Humanos. Para obtener más información sobre los requisitos de privacidad de HIPAA, los reglamentos de transacciones electrónicas y los códigos establecidos de HIPAA y las normas de seguridad de HIPAA propuestas, visite el sitio web de ACOG www.acog.org o llame al (202) 863-2584.

He leído, entiendo y doy por recibida la Notificación de Prácticas de Privacidad HIPAA de DHS.

Firma

Fecha

Nombre en letra de molde

Fact Sheet and Quick Guide to Women's Health Medical Assistance

This document is for informational purposes, only for applicants, who apply for PE WHM with Qualified Providers/Qualified Hospitals. It explains to them the MORROW Right from the Start Medical Assistance Group (MRSM) for WHM and what to expect if their application is approved for this program.

To inform the individual of the status of their Medical Assistance application. These documents contain an entry for the telephone number of the MRSM office and important information that the individual will need to know regarding renewals, reporting changes etc. DPH should give this document to the individual along with other forms the applicant will receive.

Revised 03/18/19



Quick Guide on Women's Health Medicaid

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

- You have been approved for Women's Health Presumptive Eligibility (PE) that provides eligibility from the date of your application approval until the end of the second month. Your application is being sent to the MORROW Right from the Start Medical Assistance Group (MRSIM) office to determine eligibility of ongoing coverage for Women's Health.
- If you remain eligible for Women's Health, you will be assigned an Economic Support Specialist that you can reach by calling the phone number that corresponds to the first letter of your last name. Your Economic Support Specialist may contact you for additional information.

A-D	770-960-2088	E-I	770-960-2078	J-N	770-960-2092
O-S	770-960-2084	T-Z	770-960-2081		

- You will receive a letter in the mail letting you know whether or not your application is approved or denied for ongoing eligibility. If approved, you will be covered for a year. Thereafter, your eligibility will be renewed yearly if you are still in cancer treatment. There may be other types of Medical Assistance that may cover you after that point.
- As soon as you are eligible for Medicaid, you will be auto enrolled in a Care Management Organization (CMO). You will receive a welcome package from the CMO selected. If you prefer a different CMO than the one selected, you have 90 days to change to a different CMO by contacting Georgia Families at (1-888-GA-ENROLL) or by internet at: <http://www.georgia-families.com>.
- You must call your MRSIM Economic Support Specialist within 10 days of all household changes; especially if your cancer treatment has ended.
- You will be eligible for Medicare the month you turn 65 years of age and therefore no longer eligible for Women's Health Medical Assistance. If you become eligible for Medicare prior to age 65, you are no longer eligible for WHM at that point. You will be reviewed for continuing eligibility however, please prepare for this change, so you are not without coverage. Any questions regarding Medicare can be answered by contacting Medicare at 1-800-MEDICARE (1-800-633- 4227); TTY 1-877-486-2048 or www.Medicare.gov.

If you need a replacement Medicaid card call Member Contact Center at 1-866-211-0950.

WOMEN'S HEALTH MEDICAL ASSISTANCE (WHM)

What is the Women's Health Medical Assistance Program?

WHM provides full coverage Medical Assistance for eligible women under the age of 65; who have breast and/or cervical cancer; who is in need of treatment; who have been screened through the BCCP Screening Program, who is in need of breast reconstructions and prostheses after mastectomy based on clinical justification and medical necessity documentation by the physician or surgeon, who is a Qualified Transgender; have income at or below 200% of the Federal Poverty Level (FPL); who are U.S. citizens or Qualified Immigrants; and do not have private insurance, Medicaid or Medicare.

What you should know about the process:

- The Department of Public Health explains your temporary WHM coverage during your visit with them.
- Your Presumptive Eligibility (PE) application is forwarded to the Morrow Right from the Start Medical Assistance Group (MRSM) to determine if you meet the criteria for ongoing Medical Assistance under WHM. Your Medical Assistance application for WHM can be terminated by MRSM if other circumstances are known to the agency that were not reported on your PE application.
- If verification of citizenship and identity is required, you can submit verification online at www.gstewey.ga.gov or you may call toll-free 1-800-809-7276. If you are not able to provide the requested proof of citizenship or identity by the deadline indicated; Medical Assistance for the individual may still be approved. You will have three (3) months from the date of the Medical Assistance approval notice to submit the required documents.
- Failure to cooperate with any request in a timely manner will result in your Medical Assistance being terminated. You would have to reapply for the coverage.
- You can request Retroactive Medical Assistance that will allow (up to 3 months) prior to the date of application. Income verification is required on each prior month requested. To be approved, you must meet the following criteria:
 - Income must be under 200% of the Federal Poverty Level
 - Your diagnosis must be in the three months prior to the month of your Medical Assistance application
- After your approval for Presumptive Eligibility (PE) WHM, you are auto assigned into a Care Management Organization (CMO). You will receive a welcome package from the CMO selected. If you prefer a different CMO than the one selected, you have 90 days to change to a different CMO by contacting Georgia Families at (1-888-GA-ENROLL) or by internet at: <http://www.georgia-families.com>.

Renewal Process Overview:

- Your case will be renewed every year in the month of your application. A renewal application package must be completed and returned when your renewal is due. Renewal information is mailed to the last reported address you provided. You must verify that you are currently in treatment by returning a completed Physician's Statement of Treatment form signed by an authorized professional.
- Proof of Income is required at renewal to determine your continual eligibility under Medical Assistance. Income must be under 200% of the Federal Poverty Level.
- The month after you turn 65, you are no longer eligible for this type of Medicaid Assistance even if you are still receiving treatment.

What is your responsibility?

- Report any change within 10 days of the change by going online at www.gstewey.ga.gov, contacting the RSM Medical Assistance Group by calling toll free 1-800-809-7276 or contacting your case manager printed on your letter. Reported changes include, but are not limited to:

- If your treatment ends for breast or cervical cancer
- If you had a gender and/or name change
- You move and/or your contact information changes
- Report any household income changes
- If you receive other health insurance or you become SSI and/or Medicare eligible

A – D	(770) 960-2088
E – I	(770) 960-2078
J – N	(770) 960-2092
O – S	(770) 960-2084
T – Z	(770) 960-2081

Helpful Internet Sites:

<http://www.georgiacancer.org/treat-aid.php> (404)-463-5111

<http://www.cancer.org/docroot/home/index.asp> (1-800-227-2345)



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

PRESUMPTIVE ELIGIBILITY MANUAL UPDATES

EMAIL TO: DCH: pecorrections@dch.ga.gov
Subject Line: PE Manual Update

TODAY'S DATE: _____

UPDATE FOR (check one): ☐ Pregnant Women PE Attach Form 632 ☐ Hospital PE Attach Form 632H ☐ WHM PE Attach Form 632W

Please check below which update(s) needs to be completed:

Name

Address

Social Security Number - - Date of Birth / / (MM/DD/YEAR)

Expected Birth Date of Fetus(es) / / (MM/DD/YEAR)

Number of Births

Terminate P4HB ☐

Add PE Eligibility to GAMMIS ☐ PE Eligibility Period:

Update PE aid category ☐ Correct PE aid category: Choose Item.

Duplicate ID Merge: Original Duplicate

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)

*DCH will complete updates the same business day if received by 5:00 pm. If received after 5:00 pm or on the weekend, updates will be completed the next business day.

Name of QH/QP Employee

QH/QP Employee Phone Number

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 1/15/19

Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan | Health Planning

Equal Opportunity Employer



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

Supplemental Security Income (SSI) Pregnant Women Update

FAX TO: Morrow Right from the Start Medical Assistance Group
770-960-2061

OR

Scan/Email to: womenshealth@dch.ga.gov

Member's Name	
Member's Member ID Number	
Number of Weeks Pregnant	
Expected Due Date (EDD)	
Number of Expected Fetus(es)	

CONTACT INFORMATION: *Please print clearly*

Name of person completing this coversheet	
Agency Name	
Direct phone number of person completing this coversheet	
Date faxed	

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 1/15/19

Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan | Health Planning

Equal Opportunity Employer

Statement of Treatment Form DMA 632WQP

This form should be used by QPs/QHs when a previously active PE WHM member's case was closed because she was approved for another Medical Assistance aid category, such as SSI, and then the other Medical Assistance category closes and she needs to return to WHM because she is still in cancer treatment.

There isn't a way for MORROW to know that her Medical Assistance aid category has closed, and she still qualifies for WHM unless they contact MORROW directly. It is always encouraged QPs/QHs have WHM beneficiaries contact MORROW directly with all questions regarding WHM.

When the individuals contact QPs/QHs rather than MORROW, QPs/QHs can either assist the individual directly or have them contact MORROW. If the last known Medical Assistance case is about to end or has ended within the last three (3) months, do **not** do a PE WHM application, allow MORROW to re-determine WHM eligibility.

When these individuals change Medical Assistance categories a Statement of Treatment form is required, along with possible other information/verification, in order for MORROW to determine WHM eligibility. QPs/QHs assistance is required with most of these cases to obtain the Statement of Treatment form from the Cancer Treatment Provider in order to expedite her WHM eligibility.



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

Physician Statement of Treatment for Breast and/or Cervical Cancer

This form must not be altered in any form or manner and must be completed by the physician, or an authorized licensed medical professional of the physician (i.e. LPN, RN, NP or PA), treating the patient for breast and/or cervical cancer and designated to sign on his or her behalf. Please complete and return this form by XX-XX-XXXX whether the patient is currently receiving treatment for breast and/or cervical cancer or not. If we do not receive the form, we will not be able to determine continued eligibility and the Medical Assistance case will be terminated.

Patient Full Name:			
Patient DOB		Patient SSN (if known)	
Diagnosis (Please check)			
Breast Cancer	☐ In Situ	☐ Invasive Cancer	☐ Triple Negative
Cervical Cancer	☐ CIN II	☐ CIN III	☐ Invasive Cancer
Diagnosis Date:		Print Name of Treating Physician	

I certify that the above patient is in **ACTIVE** treatment for Breast and/or Cervical Cancer by checking one of the boxes that apply.

☐ is **currently in active treatment** for breast and/or cervical cancer or pre-cancerous condition and may include: surgery, radiation, chemotherapy and hormone therapy.

Must Specify Treatment:

☐ is **NOT** currently in **active** treatment for breast and/or cervical cancer.

I certify that the above information is correct regarding my patient and by signing below, I am either a Physician or an authorized Licensed Medical Professional of the physician listed above. Any falsification of the patient's health regarding being in treatment will result in Medicaid fraud, in which you may be held liable for any claims paid on the patient's behalf.

Physician/Authorized Licensed Medical Professional Signature
(Signature Stamp Not Acceptable)

Title

Date
(Good only for 30 days)

Name of the Clinic or Office that provides the treatment: _____

Address: _____

Phone #: _____ Fax #: _____

The form may be submitted to mcmanis@dcph.ga.gov, either by fax, scanned into an email or by mail.

Caseworker Name		Email Address	
Telephone Number		Fax	
Mailing Address	1400 Southlake Plaza Dr. Morrow, GA 30260		

Revised 2/19/2019



Revised
3/11/19

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

Physician Statement of Treatment for Breast and/or Cervical Cancer

INSTRUCTIONS

In accordance with Department of Community Health (DCH) and the Georgia Department of Public Health (DPH) regulations, please follow the below direction for accurate completion of each section of the Physician's Statement of Treatment form (PST). The PST form must be completed in full and must not be altered in any form or manner.

- I. **Demographics:**
 - a. Must complete Patient Full Name
 - b. Patient Date of Birth (DOB)
 - c. Patient Social Security Number (SSN) if available
- II. **Diagnosis and Certification of Treatment:**
 - a. Must fill in the Diagnosis Date, the date cannot be left blank.
 - b. Diagnosis of Breast Cancer must be checked by indicating which type of cancer: InSitu, Invasive Cancer or Triple Negative.
 - c. Diagnosis of Cervical Cancer must be checked by indicating which type of cancer: CIN II, CIN III or Invasive Cancer
- III. **Provider's Information:**
 - a. A physician or authorized licensed medical professional must certify if patient is in ACTIVE treatment for Breast and/or Cervical Cancer, explanation of what treatment or list the Medication treatment the patient is taking for treatment such as, (Tamoxifen, Arimidex, Anastrozole, Raloxifene, Toremifene, Fulestant, Letrozole and Exemestane etc.) is considered as being in treatment for cancer.
 - b. You must specify the treatment the patient is receiving.
 - c. If the patient is NOT in active treatment the box should be checked only and no explanation is needed.
 - d. The physician or the authorized licensed medical professional signature must be in its original format certifying this information is true and accurate. A stamped signature is not acceptable.
 - e. The person completing this form must complete the name of the clinic, address, phone number and fax number.

Note: If any information on this form is falsified to assist the patient in maintaining coverage can result in Medicaid fraud.

*The customer was given her responsibilities regarding this renewal process and a deadline was given to the customer to have all information back to this office. Please be advised that failure to return the completed form, along with other requested information will terminate the Medicaid case of the customer listed above.

Healthcare Facility Regulation | Medical assistance Plans | State Health Benefit Plan | Health Planning

Equal Opportunity Employer

Revised 3/16/2019

APPENDIX G

GAMMIS

Sign on to GAMMIS:

The screenshot shows the 'Sign in to the Georgia Medicaid' page. On the left is the Georgia Department of Community Health logo and contact information. The main content area has a sign-in form with fields for 'Username' and 'Password', a 'Sign In' button, and a 'Forgot your password?' link. A 'Help' link is in the top right of the form. Annotations include: a red box 'User Name' with an arrow pointing to the Username field; a red box 'Password' with an arrow pointing to the Password field; a red box 'Get Password' with an arrow pointing to the 'Forgot your password?' link; and a red box 'To Access the Web Go Here' with an arrow pointing to the 'MEUPS Account Management' link in the Applications table.

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

Password

Get Password

Privacy

© Copyright 2007-2010 Hewlett-Packard Development Company, L.P. All rights reserved.

The screenshot shows the 'Georgia Medicaid Home' page. It includes the Georgia Department of Community Health logo and contact information. The main content area has a 'Sign Out' button, a 'Public Health Welcome to Georgia Medicaid' message, and two sections: 'Applications' and 'Messages'. The 'Applications' section contains a table with two rows: 'MEUPS Account Management' and 'Web Portal'. The 'Messages' section states 'There are no new messages.' Annotations include: a red box 'To Access the Web Go Here' with an arrow pointing to the 'MEUPS Account Management' link; a red box 'To Change Your Password and Personal Information Go Here. It Takes You Here.' with an arrow pointing to the 'Forgot your password?' link on the previous page; and a red box 'To Access the Web Go Here' with an arrow pointing to the 'MEUPS Account Management' link.

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

To Change Your Password and Personal Information Go Here. It Takes You Here.

Privacy

© Copyright 2007-2010 Hewlett-Packard Development Company, L.P. All rights reserved.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Account Home
 My Information
 Change Password
 Reports

Account Home

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.

Privacy
 © Copyright 2007-2010 Hewlett-Packard Development Company, L.P. All rights reserved.

Going to the Web:



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

GEORGIA
WEB PORTAL



GEORGIA
HEALTH
PARTNERSHIP

Search

[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
 Medicaid Provider ID
 Name

Address
 City
 Zip

If you have more than one choice choose your office.

(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.

Messages:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA WEB PORTAL

GEORGIA HEALTH PARTNERSHIP

Welcome Public Health

Search

[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 Request

User Information - Provider 000457729N

Messages

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

Select All Save Deselect All

Screening on the web portal:

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA WEB PORTAL

GEORGIA HEALTH PARTNERSHIP

Welcome Public Health

Search

[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 Eligibility Request

User Information - Provider 0004577

Newborn Activations

Pregnant Women Activations

Women's Health Activ

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.

Eligibility Verification Request

Member ID Birth Date

Last Name SSN

First Name From/Thru

Gender Date of Service

search clear

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

Eligibility Verification Request

Member ID: 111222333444 Birth Date: [] SSN: []
 Last Name: [] First Name: [] Date of Service: 09/30/20XX 10/24/20XX
 Gender: []

Member ID Information

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 Confirmation #: 122770010D

Eligibility Spans

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 the applicant has never had Medical Assistance this screen will not appear.

The following messages were generated:

Message Description	Panel	Field	Row
73 - No match using search criteria SSN: 123456789, DOB: 19881204, Name: SMITH, L.	Eligibility Verification Request		

Eligibility Verification Request

Member ID: [] Birth Date: 12/04/1988 SSN: 123-45-6789
 Last Name: SMITH First Name: L Date of Service: 08/26/2013 09/30/2013
 Gender: Female Service Type: 30 - Health Plan Benefit Coverage

If your applicant does not have active Medical Assistance nor has ever been known to the system you can process the PE application online. Use the PE tab:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH **GEORGIA WEB PORTAL** **GEORGIA HEALTH PARTNERSHIP**

Welcome Public Health

[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/Medication Aide | EDI | Pharmacy
 Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | GBHC Referral | Reports | Trade Files
 Home Newborn Activations Pregnant Women Activations Women's Health Activations

The PE Screen will appear:

Presumptive Eligibility for Women's Health Medicaid Request

Old Information

Net Income* \$1,500.00

Member Information

Member ID

First Name* SENECA

Last Name* SIMMONS

MI

Suffix

Race* White (Non-Hispanic)

Citizenship* US CITIZEN

Birth Date* 01/11/1955

SSN 000-00-0000

Home Phone

Other Phone

Ethnicity* Ethnicity Unknown

Primary Household Language* ENGLISH

Mailing Address

Address* 8866 RAINBOW LANE

Address 2

City* LAWRENCEVILLE

Zip* 30043 0000

Residential Address

Same as Mailing Address ☒

Address

Address 2

City

Zip

Eligibility Information

Medicaid Application Submitted?* NO

Determination/Eligibility Begin Date 02/16/2015

State* GA

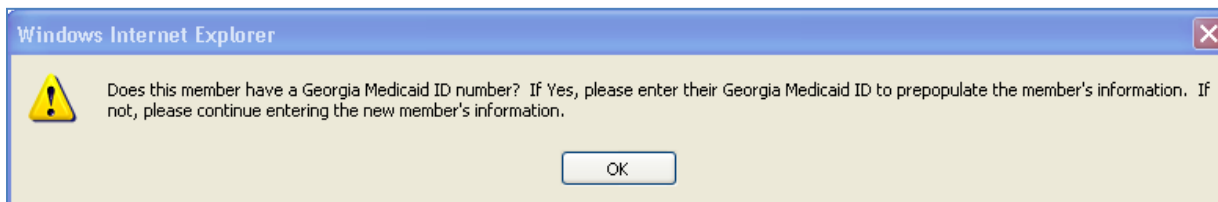
County* 067-Gwinnett

State

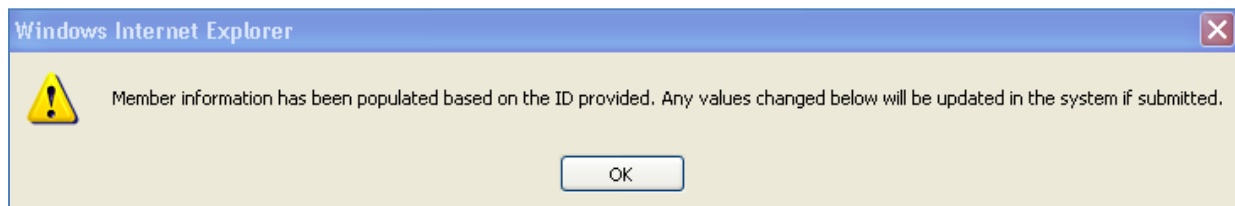
County

Application Date* 02/16/2015

Enter the member'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 Manual Updates procedure after you enter the PE on 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 and cannot be modified.

<u>Eligibility Information</u>	
Medicaid Application Submitted?*	NO v
Determination/Eligibility Begin Date	02/16/2015

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.



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 page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.	
submit cancel	
Presumptive Eligibility for Women's Health Care Request <input <="" td="" type="button" value="?"/>	
<u>Member Info</u>	

The presumptive eligibility request was successfully processed message will appear:

The following messages were generated:	
The presumptive eligibility request was successfully processed. The Medicaid ID is 111122233334444. Select the following link open a certificate of eligibility , if a window does not appear or if you close the initial certificate.	
Presumptive Eligibility for Women's Health Care Request <input <="" td="" type="button" value="?"/>	
<u>Member Info</u>	

The first four digit of the member's Medicaid ID will start with 1111 or 2222.

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

	GEORGIA DEPARTMENT OF COMMUNITY HEALTH	GEORGIA WEB PORTAL	
Welcome, Wilkes Co Board Of Health Pcm			Search
[Refresh session] You have approximately 19 minutes until your session will expire.			Tuesday, September 10, 2013
Temporary Member Identification Card			
Please note: Once the user navigates from this confirmation page, this information will no longer be accessible outside of performing an eligibility request on the member below. Therefore, please use your browser to print this confirmation page before closing. Thank you for your participation in the Medicaid/PeachCare for Kids® program. Your presumptive eligibility entry has been received. The Member ID is listed below. This is the number you will need to use when submitting claims for services rendered to this member. Please check the member eligibility site regularly for updates to this member's eligibility information. You may also access current eligibility information by clicking "Contact Us" under the Contact Information tab in the upper top left of your web screen; or by calling the Provider Contact Center at 1-800-766-4456; or by using the Interactive Voice Response (IVR) System at 1-800-766-4456. This temporary member identification card may be used as a confirmation of presumptive eligibility for the Medicaid program as of the indicated date. A permanent identification card will be mailed to the member at the address below. Please print this page for the member to use until their member ID card arrives. A Division of Family and Children Services Medicaid Eligibility Specialist will contact the member about her eligibility. Rx BIN Number: 001553			

Welcome, Wilkes Co Board Of Health Pcm

Search

Refresh session] You have approximately 19 minutes until your session will expire.

Tuesday, September 10, 2013

Temporary Member Identification Card

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

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

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

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

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

Rx BIN Number: 001553

Eligibility Verification Request

?

From/Thru
Date of Service 08/01/2013 09/30/2013
Service Type 30 - Health Plan Benefit Coverage

Eligibility Spans									
Status	Service Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes	Special Notes or Limitations	
Active	1 - Medical Care	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Inactive for Service Type Code selected.	33 - Chiropractic	08/01/2013	09/30/2013						
Active	35 - Dental Care	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	47 - Hospital	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	48 - Hospital - Inpatient	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	50 - Hospital - Outpatient	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	86 - Emergency Services	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	88 - Pharmacy	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	98 - Professional (Physician) Visit - Office	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	AL - Vision (Optometry)	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	MH - Mental Health	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	
Active	UC - Urgent Care	08/01/2013	09/30/2013	MC - Medicaid	800 - Presumptive BCC	0.00		MEDICAID	

Appendix I- INCOME

SOURCE OF INCOME	DESCRIPTION
ADOPTION ASSISTANCE	Unearned - Money received for the adoption of certain children. Exclude
ADVANCE (not a prepayment of wages or salary)	Unearned - Money for future expenses that does not represent a gain to the budget unit. Exclude
AGENT ORANGE PAYMENTS	Unearned - Payments made to Vietnam veterans exposed to Agent Orange Defoliant and to their surviving spouse and children. Exclude
ALASKA NATIVE CLAIM	Unearned - Payments made under the Alaska Native Claims Settlement Act. Exclude
ALIMONY/SPOUSE SUPPORT	Unearned – A court-ordered payment from an estranged spouse or former spouse to the other spouse. Include
BLOOD, THE SALE OF	Earned – Money received from the sale of blood including blood products. Include
(TEMPORARY) CENSUS BUREAU EARNINGS	Earned - Remuneration paid for temporary employment related to census activities. Exclude
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATIONS NOT STATE OR FEDERALLY FUNDED	Unearned - Contribution to the budget unit. Exclude all that are not from the state or federally funded agencies.
CHILD'S EARNINGS	Earned - Income earned by a child under age 19. Exclude
CHILD SUPPORT	Unearned – Income received for the support of the 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. Include
COMMISSION	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. Include
CONTRIBUTION, GIFT, PRIZE, AWARD	Unearned – Money is given to the AU as a gift from individuals or organizations. Include
DISASTER RELIEF	Unearned - Governmental payments for the restoration of a home damaged by a disaster. Exclude

DIVERTED INCOME	Unearned – Money deducted or diverted by a court order to a third party. Exclude 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. Include
EARNED INCOME TAX CREDIT	Unearned - IRS credit received as advanced payments as part of a regular paycheck or received a part of an income tax refund (EITC). Exclude
EDUCATIONAL GRANT, LOAN, SCHOLARSHIP	Unearned - Payments for educational assistance of a budget unit member. Exclude
ENERGY ASSISTANCE	Unearned - Payment or allowance received under federal, state, or local laws for utility expenses. Exclude
FEDERAL PROGRAMS	Unearned • 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 Exclude
FOSTER CARE PAYMENTS	Unearned – (IV- B) per diem payments received by the foster parents to provide for the needs of the foster child and foster family. Exclude (IV-E) per diem payment received to provide for the needs of the foster child. Exclude as income to the foster child.
GARNISHMENT	Earned/Unearned – A set amount of wages or monies withheld by an employer/entity to pay a debt owed to a third party. Include
GENERAL ASSISTANCE	Unearned – payments received by the Applicant/Member from county funds administered by DFCS. Exclude 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. Exclude

HOUSING and URBAN DEVELOPMENT (HUD) RENTAL REFUND	Unearned - Payment received by the budget unit for rent or utility expenses or paid directly to the landlord for rent or utility expenses on behalf of the budget unit. Payments sometimes are distributed by the Georgia Residential Financial Authority. Exclude
INDIAN LAND GRANTS	Unearned - Federal distribution to members of Indian Tribes. Exclude
IN-KIND INCOME	Unearned - Any gain or benefit which is not in the form of money payable directly to the budget unit such as meals, clothing, or produce. Exclude Earned – Wages may include the value of food, clothing, shelter or other items provided in lieu of cash wages. Exclude
JURY DUTY	Earned – Compensation received for serving on a jury. Include
LOANS (PERSONAL OR BUSINESS)	Unearned - Money received that the borrower has an obligation to repay. Requires a repayment agreement (written or oral). Exclude Unearned - Money loaned to persons outside the BG where a repayment agreement exists. Payments received are considered income. Include
MILITARY PAY	Earned - Military personnel benefits as reported on Leave and Earnings Statement (LES). Include
REIMBURSEMENT	Unearned - Payment for past expenses that does not represent a gain or benefit to the budget unit. Exclude
RELOCATION ASSISTANCE	Unearned - Money paid under Title II of the Uniform Relocation Assistance & Real Property Acquisition Act of 1970. Exclude
REPAYMENT OF OVERPAYMENT OF BENEFITS THROUGH BENEFIT REDUCTION IN RSDI, UCB (or others)	Unearned – Money withheld from the income source to repay a previous overpayment. Do not count the repayment amount. Count the gross minus the repayment amount. Exclude
RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI)	Unearned – Social Security benefits paid to an insured worker or dependent on the basis of the retirement, death or disability of the worker. Include
SELF EMPLOYMENT EARNINGS (NET)	Earned – income from a self-employed enterprise. Include

SEVERANCE PAY	Earned – Money received from the former employer <u>upon</u> termination of employment. Include Unearned - payments received from a former employer <u>after</u> termination of employment. Include
SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (GREEN THUMB)	Earned - Title V income paid for part-time employment to individuals over age 55. Exclude
SUPPLEMENTAL SECURITY INCOME (SSI)	Unearned - Benefits from a federal program for Aged, Blind, or Disabled individuals administered by the Social Security Administration. Exclude
TAX REFUND	Earned/Unearned - A refund of taxes paid on food, income or property. It may be considered as earned or unearned. Exclude
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments. Exclude
TIPS	Earned – Voluntary payments above the stated cost of a product or service given in appreciation for the service rendered. Include
UNEMPLOYMENT COMPENSATION BENEFITS (UCB)	Unearned – Benefits received from the Department of Labor (DOL) by unemployed individuals. Usually received weekly. Include
VACATION PAY	Earned – Any amount paid to employees for a regularly scheduled period spent away from work or regular duty. It includes amounts paid even if the employee chooses not to take a vacation. Include
VENDOR PAYMENT	Unearned - Money paid by an outside source to a third party on behalf of the budget group for an expense. Exclude
VETERANS ADMINISTRATION BENEFIT	Unearned - Benefits received by veterans from the Veterans Administration for: Pension – Include Disability Compensation – Include VA provides compensation to Veterans who are at least 10% disabled because of injuries or diseases that occurred or were aggravated during active military service. Educational – Exclude Aid and Attendance – Exclude Household Allowance – Exclude Clothing Allowance – Exclude Augmented Benefits – Include (for dependent(s), income is counted for dependent(s).)

WAGES (SALARY)	Earned – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis. Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee's share of FICA when paid by the employer. Include
WORKER'S COMPENSATION	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 applicant in connection with the claim. Include
WORK STUDY PROGRAM	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money. Exclude

CONVERSION CHART

IF PAID	THEN
HOURLY	Multiply the number of hours worked per week times the hourly wage times 4.3333 weeks;
WEEKLY	Multiply gross income times 4.3333;
SEMI-MONTHLY	Multiply semi-monthly gross income times 2;
YEARLY	Divide yearly gross income by 12.

FEDERAL POVERTY GUIDELINES

FAMILY SIZE	MONTHLY INCOME LIMIT
1	\$1980
2	\$2670
3	\$3360
4	\$4050
5	\$4740
6	\$5430
7	\$6122
8	\$6816

EACH ADDITIONAL PERSON:
ADD \$694

Effective for Determinations Made on or After April 1, 2016

APPENDIX M MEMO

[illegible]

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.

Revise
03/14/16

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 Memi Wilson 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 Medical Assistance Group
Mandy Corlee, Project Manager, DHS Right from the Start Medical Assistance Group
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

Revi
03/1

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

Revi:
03/1.

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

Rev
03/

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.

Revi.
03/1.

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).

Revise
03/14/16

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 PROCUDURES

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

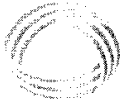
Residential County Code

Social Security Number

Date of Birth

Duplicate ID Merge

Application Date



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

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.

Revi:
03/1.

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):	☐	PE PREGNANCY Attach Form 632	☐
			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 ☐

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) ☐

Revi:
03/1.

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.



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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 ☐

Revi:
03/1.

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.

Health Information Technology | Healthcare Facility Regulation | Medicaid | State Health Benefit Plan



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

Revi:
03/1.



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.

Revi
03/1

<u>Federal Poverty Guidelines</u>	
<u>Family Size</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



April 15, 2013

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 
DCH Medicaid Eligibility & Policy

SUBJECT: GAMMIS update for SSI Pregnant Members

The Department of Community Health (DCH) has updated the Georgia Medicaid Management System (GAMMIS) to exclude co-payment for all pregnant women, regardless of class of assistance. The exception is pregnant Supplemental Security Income (SSI) members. We have developed a solution to have their pregnancy information updated in GAMMIS so that these pregnant women will also be excluded from co-payment.

Any SSI pregnant member that contacts the Department of Public Health (DPH) regarding pregnancy can be serviced by the DPH for pregnancy verification. DPH staff will complete the SSI Pregnancy Update Coversheet (attached), add their county office letterhead, and fax the SSI Pregnancy Update Coversheet to the HP Member Contact Center to have GAMMIS updated with her pregnancy information.

DPH staff will continue to contact the Right from the Start (RSM) ARROWHEAD office for any active Women's Health Medicaid (WHM) members that become pregnant, as outlined in the Presumptive Eligibility (PE) WHM manual.

The Division of Family and Children Services (DFCS) and the Right from The Start (RSM) Outreach Project are to follow the SSI pregnant member process outlined for them.

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.

Attachment:

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
Gwendora Bailey, RSM Project Director
Sophia Jefferies, Program Consultant, Division of Public Health
Cathy Broom, Program Consultant, Division of Public Health
Tara Dickerson, DCH Legal Services
Federally Qualified Health Centers/Rural Health Centers



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.

Revi:
03/1.

Federal Poverty Guidelines

<u>Family Size</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



December 23, 2013

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

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

Yvonne Greene

RE: Affordable Care Act Changes for Presumptive Eligibility Medicaid

The purpose of this Memorandum is to inform Qualified Providers (QP) of the Affordable Care Act (ACA) changes to the Presumptive Eligibility (PE) Medicaid effective January 1, 2014.

FEDERAL POVERTY LEVEL (FPL)

For PE Pregnancy Medicaid and PE Women's Health Medicaid (WHM) the FPL will increase from 200% to 220%. The Centers for Medicare and Medicaid Services (CMS) provided clarification on how to calculate the 5% FPL deduction amount, disregard any previous income charts that were distributed.

Family Size	PGW		5% Disregard amount	Family Size	PGW		5% Disregard amount
	220%	Plus 5%			220%	Plus 5%	
1	\$2,108	\$2,156	\$48	11	\$9,478	\$9,694	\$216
2	\$2,845	\$2,910	\$65	12	\$10,215	\$10,448	\$233
3	\$3,582	\$3,664	\$82	13	\$10,952	\$11,201	\$249
4	\$4,319	\$4,418	\$99	14	\$11,689	\$11,955	\$266
5	\$5,056	\$5,171	\$115	15	\$12,426	\$12,709	\$283
6	\$5,793	\$5,925	\$132	16	\$13,163	\$13,463	\$300
7	\$6,530	\$6,679	\$149	17	\$13,900	\$14,216	\$316
8	\$7,267	\$7,433	\$166	18	\$14,637	\$14,970	\$333
9	\$8,004	\$8,185	\$182	19	\$15,374	\$15,724	\$350
10	\$8,741	\$8,939	\$199	20	\$16,111	\$16,478	\$367



Dr. Seema Czukas
Affordable Care Act Changes for Presumptive Eligibility Medicaid
Page 2 of 3

FORMS

The PE application forms 632 (PE Pregnancy) and 632W (PE WHM) have been revised.

The single streamlined application will be used as the full Medicaid application for PE Pregnancy Medicaid. The current full Medicaid application form 94 will continue to be used for PE WHM.

The HIPAA form 5460 was revised and should be used when the Division of Family and Children Services (DFCS), or the Right from the Start (RSM) Project, is able to supply QPs the revised form. Only the signature page four (4) will need to be included in the PE Packets. The current HIPAA form 5460 can be used until the revised form has been supplied, or QPs in house HIPAA form can be used temporarily so the cost of copies is not incurred.

DCH has requested all original versions of the HIPAA form 5460 from DFCS' central supply be delivered to the local DPH offices as these forms are still valid until supplies have been depleted.

Copies of these forms are attached to this Memorandum and are included in the PE manuals on line for January 1, 2014.

ACA CHANGE FOR PE MEDICAID

The PE Pregnancy Medicaid determination process will change significantly due to the ACA. These changes are included in the updated PE ACA Pregnancy Manual available January 1, 2014 on the Georgia Medicaid Management Information System (GAMMIS) Web Portal. DCH completed introduction training on these changes in October 2013.

PE WHM Medicaid will only have the FPL change and updated form 632W; no other changes will occur. PE WHM changes are included in the updated PE ACA WHM Manual available January 1, 2014 on the GAMMIS Web Portal.

QP workers that complete both PE Pregnancy and PE WHM Medicaid must be cautious of the differences in determining PE Medicaid beginning January 1, 2014.

PE TRAINING

Due to changes with the VICs scheduling, PE Pregnancy and PE WHM training dates will be still be conducted quarterly; however, the dates will be different and announced once DCH receives the confirmation of the new dates for 2014.



Dr. Seema Csukas
Affordable Care Act Changes for Presumptive Eligibility Medicaid
Page 3 of 3

PREGNANCY CORRECTIONS

Changes with the ACA require PE Pregnancy Medicaid to accept the applicant's statement of pregnancy and the number of expected births. Medical verification is not allowed prior to the PE Pregnancy approval. If the applicant is approved for PE Pregnancy Medicaid and it is discovered afterwards that she is not pregnant, this case must be reported to DCH immediately for closure.

Email Menni Wilson at nwilson@dch.ga.gov with the subject line indicating PE closure. The email will contain the beneficiary's name and member ID number to be closed; or fax the 632 form indicating on the form she is not pregnant to 770-344-4232.

QUALIFIED HOSPITALS

The ACA requires that Qualified Hospitals (QH) have the option to complete PE Medicaid for Pregnancy, WHM, Parent/Caretaker with Child(ren), Children Under 19 Years of Age, and Former FosterCare Medicaid. Successful completion of PE training is required for QHs making PE determinations.

CMS must approve the PE Hospital Manual and updates to GAMMIS must be completed prior to allowing QHs to complete PE Medicaid applications.

PE training will be completed quarterly at DCH. The first training is scheduled February 5, 2014 with additional training offered the first Wednesday in April, July and October; WebEx training and onsite training will also be available.

ATTACHMENTS

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Jonathan Duttweiler, Medicaid Policy Unit Manager, DFCS Office of Family Independence
Judy Adan, Interim RSM Project Director
Tara Dickerson, DCH Legal Services Director
Wesley Merritt, DCH QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara E. Crane, Director, Office of Cancer Screening and Treatment, DPH
Cathy Broom, Program Consultant, DPH
Barbara Vance, Myers and Stauffer



January 14, 2014

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

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

RE: Presumptive Eligibility Medicaid Training

The purpose of this Memorandum is to inform Qualified Providers (QP) and Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Training dates for 2014 and also to provide information about the additional page on PE Medicaid applications to add budget group members.

PE PREGNANCY MEDICAID

Quarterly VICs PE Pregnancy Medicaid training is scheduled to begin at 9:00 AM and end at 3:00 PM on the dates and at the locations listed below. Lunch is planned for 12:00 PM to 1:00 PM.

- February 26th (10th floor)
- May 28th (16th floor)
- August 27th (16th floor)
- November 26th (16th floor)
- January 23rd has been scheduled as a specialized training for PE Pregnancy Budget Groups training (16th floor).

PE WOMEN'S HEALTH MEDICAID (WHM)

Quarterly VICs PE WHM training is scheduled to begin at 9:00 AM and end at 3:00 PM on the dates and at the locations listed below. Lunch is planned for 12:00 PM to 1:00 PM.

- February 20th (10th floor)
- May 15th (16th floor)
- August 21st (16th floor)
- November 20th (16th floor)



Dr. Seema Csukas
Presumptive Eligibility Medicaid Training
Page 2 of 3

PE HOSPITAL MEDICAID TRAINING

Quarterly PE Hospital Medicaid training is scheduled to begin at 9:00 AM and end at 3:00 PM. Lunch is planned for 12:00 PM to 1:00 PM. Training will take place on the dates listed below in the Department of Community Health, 5th floor Overflow room. DCH is located at #2 Peachtree Street, Atlanta Georgia 30303.

- February 5th
- April 2nd
- July 2nd
- October 1st

FORMS

A second page has been created for Qualified Providers and Qualified Hospitals to add budget group members if additional lines are needed. This second page can be used for PE Medicaid application forms 632 PE Pregnancy Medicaid, 632W PE WHM and 632H Qualified Hospital Presumptive Eligibility Determination.

When page two is used it will be included in the PE Packet. All PE Pregnancy Packets will continue to be given to the Right from the Start Medicaid (RSM) Project or the Division of Family and Children Services (DFCS) office; all PE WHM Packets will continue to be faxed to ARROWHEAD daily; all PE Hospital Packets will be faxed to DCH daily.

ATTACHMENT

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Jonathan Duttweiler, Medicaid Policy Unit Manager, DFCS Office of Family Independence
Judy Adan, Interim RSM Project Director
Tara Dickerson, DCH Legal Services Director
Wesley Merritt, DCH QC Program Director 2
Sheila 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



April 7, 2014

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

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

YB

RE: Presumptive Eligibility Medicaid Federal Poverty Levels and Forms

The purpose of this Memorandum is to inform Qualified Providers (QP) and Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2014 and to provide the revised PE forms.

Revi:
03/1.

FEDERAL POVERTY LEVEL (FPL)

As a result of the Affordable Care Act (ACA) the Centers for Medicare and Medicaid Services (CMS) increased the FPL for PE Pregnant Women Medicaid from 200% to 220% effective January 1, 2014. This year, Georgia will implement the annual cost of living increase effective April 1, 2014.

PE Pregnant Women Medicaid 220% FPL Effective 4/1/14

Budget	220%	5%	220%	Budget	220%	5%	220%
Group	FPL	Deduction	Plus 5%	Group	FPL	Deduction	Plus 5%
1	N/A	N/A	N/A	11	9589	218	9807
2	2885	66	2951	12	10335	235	10570
3	3631	83	3714	13	11081	252	11333
4	4374	100	4474	14	11827	269	12096
5	5118	117	5235	15	12573	286	12859
6	5864	134	5998	16	13319	303	13622
7	6607	151	6758	17	14065	320	14385
8	7351	168	7519	18	14811	337	15148
9	8097	184	8281	19	15557	354	15911
10	8843	201	9044	20	16303	371	16674

Add \$746 to the net income limit, and \$17 to the deduction, for any additional individual(s) added.



Dr. Seema Csukas
Presumptive Eligibility Medicaid Federal Poverty Levels and Forms
Page 2 of 4

The FPL for PE Women's Health Medicaid (WHM) remained 200% effective January 1, 2014 through March 31, 2014. This year Georgia will implement the annual cost of living increase effective April 1, 2014.

PE Women's Health Medicaid 200% FPL Effective 4/1/14

Budget	200%	Budget	200%
Group	FPL	Group	FPL
1	1946	11	8716
2	2622	12	9394
3	3300	13	10072
4	3976	14	10750
5	4652	15	11428
6	5330	16	12106
7	6006	17	12784
8	6682	18	13462
9	7360	19	14140
10	8038	20	14818

Add \$678 to the net income limit for any additional individual(s) added.

FORMS

The PE Medicaid forms have been updated as fillable PDF forms. Instructions for completion are located in each PE Medicaid manuals.

DMA 632 PE Pregnant Women Medicaid Application
DMA 632/632H PE Medicaid Page 2
DMA 632W PE Women's Health Medicaid Application
DMA 632W PE WHM Page 2
DMA 634 Approval Notice of Action for PE Pregnant Women Medicaid
DMA 634 Denial Notice of Action for PE Pregnant Women Medicaid
DMA 634W Approval Notice of Action for PE WHM
DMA 634W Denial Notice of Action for PE WHM

Page two (2) of DMA 632/632H and DMA 632W is used when more space is needed for additional household members and should be included in the PE Packet when used. All PE Pregnancy Packets will continue to be given to the Right from the Start Medicaid (RSM) Project or the Division of Family and Children Services (DFCS) office; all PE WHM Packets will continue to be faxed to ARROWHEAD daily; all PE Hospital Packets will be faxed to DCH daily.



Dr. Seema Csukas
Presumptive Eligibility Medicaid Federal Poverty Levels and Forms
Page 3 of 4

The Quick Guide for Women's Health Medicaid and Pregnant Women Medicaid forms have also been updated.

THIRD PARTY LIABILITY (TPL)

A Third Party resource means any individual, entity or program that is or may be liable to pay all or part of the costs for medical assistance furnished under Medicaid.

The Department of Community Health (DCH) requires all Medicaid providers to take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under Medicaid. Medicaid is the secondary payer of claims when a TPL exists and providers should file Medicaid claims accordingly. DCH has developed a process for the Department of Public Health (DPH) to follow should an error code appear for a Medicaid claim after the TPL was billed. DPH should refer to their District Billing Supervisor on the procedures to follow. All other claim issues are to be referred to the DPH's Provider Representative by calling 1-800-766-4456 or using the Contact Us feature on the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov/portal.

A DMA 285 form should be completed after a PE application has been approved, if TPL is discovered either verbally by the beneficiary or the TPL is listed on GAMMIS.

The only requirement for a PE beneficiary is to agree to cooperate with Medicaid regarding their TPL by completing the top part of the DMA 285 form and sign/date both signature sections at the bottom. If the beneficiary indicates they no longer have the TPL listed on GAMMIS, have them complete these same sections and indicate on the DMA 285 "Cancelled".

The beneficiary is not required to provide their insurance card, but if they have it with them the QP/QH should make a photocopy of the front and back of the card. Write the beneficiaries name and Medicaid ID number on the photocopy and include this page with the DMA 285 form to be either mailed (new address) or faxed to:

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

The DMA 285 form is located in the PE Manuals and on GAMMIS.



Dr. Seema Csukas
Presumptive Eligibility Medicaid Federal Poverty Levels and Forms
Page 4 of 4

PE PREGNANCY CORRECTIONS

Changes with the Affordable Care Act (ACA) require QPs/QHs to accept the applicant's statement of pregnancy and the number of expected births. Medical verification is not allowed prior to the PE Pregnant Women Medicaid approval. If the applicant is approved for PE Pregnant Women Medicaid, and it is medically verified afterwards that she is not pregnant, this case must be reported to DCH immediately for closure.

Email Memi Wilson at mwilson@dch.ga.gov with the subject line indicating PE closure. The email will contain the beneficiary's name, member ID number, and the date of the medical verification the beneficiary is not pregnant. If the PE Pregnant Women Medicaid was approved the same day, fax the PE Pregnant Women Medicaid packet and include a copy of the email to 770-344-4232; DCH will forward the PE packet to the Division of Family and Children Services (DFCS) for immediate action.

PE PREGNANT WOMEN MEDICAID CLOSURES

When a beneficiary's PE Pregnant Women Medicaid case has closed, and the full Medicaid case has not updated, DPH will speak with their Right from the Start Medicaid (RSM) worker to resolve. QPs/QHs are not authorized to complete back-to-back PE applications. The ACA only allows one approved PE Pregnant Women Medicaid per the same pregnancy.

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 questions or need additional information please contact Memi Wilson, mwilson@dch.ga.gov, Family Medicaid Program Consultant, at 404-463-0521.

ATTACHMENTS

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Jonathan Duttweiler, Medicaid Policy Unit Manager, DFCS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, DCH Legal Services Director
Wesley Merritt, DCH QC Program Director 2
Sheila 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



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

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

Budget	220%	5%	220%
Group	FPL	Deduction	Plus 5%
1	N/A	N/A	N/A
2	2921	67	2988
3	3684	84	3768
4	4446	102	4548
5	5209	119	5328
6	5972	136	6108
7	6734	154	6888
8	7497	171	7668
9	8260	188	8448
10	9022	206	9228
11	9785	223	10008
12	10548	240	10788

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



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

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 *YAG*
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.

Dr. Seema Csukas

GAMMIS changes for Presumptive Pregnant Women and Presumptive Women's Health
Medicaid

Page 2

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

MEMORANDUM

TO: Dr. Seema Csukas, Director
Maternal and Child Health Section, Department of Public Health

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2016

DATE: February 19, 2016

The purpose of this memorandum is to inform Qualified Providers (QP) and Qualified Hospitals (QH) 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, 2016.

PE Pregnant Women Medicaid FPL at 220% effective April 1, 2016

Budget	220%	5%	220%
Group	FPL	Deduction	Plus 5%
1	N/A	N/A	N/A
2	2937	67	3004
3	3696	84	3780
4	4455	102	4557
5	5214	119	5333
6	5973	136	6109
7	6735	154	6889
8	7498	171	7669
9	8262	188	8450
10	9023	206	9229
11	9786	223	10,009
12	10,550	240	10,790

Add \$764 to the net income limit, and \$18 to the deduction, for any additional individual(s) added



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

Dr. Seema Csukas

Page 2

February 19, 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	200%
Group	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 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 Lorraine Russell, Healthcare Program Consultant 3, at 404-651-9978.

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
James Knox, Director, Medicaid Legal Services
Randall Solomon, Member Enrollment Director
Wesley Merritt, QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer

Breast and Cervical Cancer Program

Clinical Services Section

Policy No. 18 Breast Cancer Screening and Diagnostic Services for the Transgender Woman

Date Created: 2016 Approved by: BCCP Administration Leadership

Date Revised: _____

POLICY

Transgender women (male-to-female), who have taken or are taking hormones and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services. Federal funds may be used to screen these transgender women. There is limited data regarding the risk of breast cancer among transgender women, however, evidence has shown that long term hormone use does increase the risk for breast cancer among women whose biological sex was female at birth.

Transgender men (female-to-male) may still receive cancer screenings if they have not had a bilateral mastectomy or total hysterectomy.



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: Ginger Henry, Medicaid Policy Unit Manager
DFCS Office of Family Independence

FROM: Yvonne Greene, Sr. Manager, Business Operations 
DCH Medicaid Eligibility and Policy

DATE: July 18, 2016

RE: Policy Update: Women's Health Medicaid - Transgender Woman ■

The Breast and Cervical Program (BCCP) Breast Cancer Screening and Diagnostic Services for Transgender Woman has been updated to reflect that a transgendered woman is eligible for Women's Health Medicaid (WHM) based on BCCP Manual, Clinical Services Section, Policy No. 18.

POLICY:

Transgender women (male-to-female), who have taken or are taking hormones and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services. Federal funds may be used to screen these transgender women. There is limited data regarding the risk of breast cancer among transgender women, however, evidence has shown that long term hormone use does increase the risk for breast cancer among women whose biological sex was female at birth.

Transgender men (female-to-male) may still receive cancer screenings if they have not had a bilateral mastectomy or total hysterectomy. If he meets all BCCP requirements, he may be eligible for WHM.

Therefore, a woman may be enrolled in the Breast and Cervical Cancer Program (BCCP) and WHM when all of the following eligibility requirements are met.

- The woman is at or below 200% of the Federal poverty level.
- The woman is uninsured.
- The woman is within the age requirements for federal or state funding.
- The client is a biological female or transgender woman.
- The woman is a resident of Georgia.



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Ginger Henry

Page 2

July 18, 2016

Please update the Office of Family Independence Medicaid manual and notify staff of the updated policy¹⁸ noted in Clinical Services Section, regarding transgender woman. Please contact Lorraine Russell at 404.651.9978 or lrussell2@dch.ga.gov if you have additional questions.

cc: Linda Wiant, Pharm.D, Chief, Medical Assistance Plans
Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Lucy Smith, Field Operations Director, DHS Office of Family Independence
Kristen Hernandez, Right from the Start Assistance Group Director
Tara Dickerson, Deputy General Counsel
Wesley Merritt, Quality Control Program Director
Sheila Alexander, PeachCare for Kids® Program Director 2
Barbara Vance, Myers and Stauffer

**News from the Office of the Regional Health Administrator
U.S. Department of Health and Human Services (HHS)
Region IV**

RHA News Update – December 16, 2016

Revised 8/17/2018

HHS News

*****Breast Reconstructions and Prostheses after Mastectomy** - Health care providers! Federal Law mandates that many health plans include coverage of breast reconstructions and prostheses any time after mastectomy. Support your patients by reviewing and sharing this Office on Women's Health fact sheet on breast reconstruction and patient rights. It provides answers to basic questions, shows how surgeons reconstruct breasts using implants or tissue from a woman's own body, and outlines the recovery, possible complications and other considerations of both surgical options. Learn your patients' rights so you can support them before, during, and after a mastectomy and inform breast cancer patients anticipating surgery about the availability and coverage of breast reconstruction, prostheses, and other options.



February 10, 2017

Dear Beneficiary,

The State of Georgia as of February 6, 2017 transitioned to a new eligibility system called Georgia Gateway. Here is some important information to know about this change.

What is the Georgia Gateway Customer Portal?

The Georgia Gateway Customer Portal is a website that allows individuals and community based organizations to screen, apply for, and renew a broad range of public service benefits administered by various State agencies in Georgia. The Customer Portal will replace the existing system where new and existing customers can apply for, manage, and renew their benefits for up to six programs. In addition to being able to request benefits, customers with a Customer Portal account can also check the status of their application once submitted, view details about their benefits, and report changes. The new Georgia Gateway system does not change existing eligibility requirements.

In order to renew your case online you will need to create an account in GA Gateway at www.cp.gateway.ga.gov. We are updating your information in GA Gateway to ensure your benefits are managed correctly. However, some forms will look different from what have been previously sent to you. It will look like you have made a new application, but we are only renewing your benefits at this time. If you have any questions about this process, please call your worker (workers name) at (workers phone number) or you may call our statewide Right from the Start Medical Assistance Group Helpline at 1-800-809-7276.

Best Regards,
Right from the Start Medical Assistance Group (RSM)
Morrow WHM Department

MEMORANDUM

TO: Carrie Summers, VP, Healthcare Financing
Georgia Hospital Associations

FROM: Yvonne Greene, Sr. Manager, Business Operations
DCH Medicaid Eligibility & Policy

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2017

DATE: February 15, 2017

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2017 Federal Poverty Level (FPL) income limits for Presumptive Eligibility (PE) Medicaid. The following FPL and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2017 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. These new income limits should be used for all PE determinations completed by Qualified Hospitals effective April 1, 2017.

Budget Group	5% Deduction	Parent/Caretaker with Children under age 19	133% Children 6-19	149% Children 1-5	205% Children 0-1	220% PGW
1	51	310	1,337	1,498	2,061	N/A
2	68	457	1,800	2,017	2,775	2,978
3	86	551	2,264	2,536	3,489	3,744
4	103	653	2,727	3,055	4,203	4,510
5	120	752	3,190	3,574	4,917	5,277
6	138	826	3,654	4,093	5,631	6,043
7	155	903	4,117	4,612	6,345	6,809
8	173	970	4,580	5,131	7,059	7,576
9	190	1,034	5,043	5,650	7,773	8,342
10	207	1,113	5,507	6,169	8,487	9,108
11	225	1,194	5,970	6,688	9,202	9,875
12	242	1,244	6,433	7,207	9,916	10,641

For each additional person over Budget Group size 12:

Add \$50 (Parent/Caretaker with Children under 19)

Add \$462 (133% FPL)

Add \$517 (149% FPL)

Add \$711 (205% FPL)

Add \$763 (220% FPL)

Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level.

Budget Group	200% WHM
1	2,010
2	2,707
3	3,404
4	4,100
5	4,797
6	5,494
7	6,190
8	6,887
9	7,584
10	8,280
11	8,977
12	9,674

For each additional person over Budget Group size 12 add \$694

Please distribute to all Hospital Staff, Supervisors and members of the QH team that process PE Parent/Caretaker with Children under age 19 Medicaid, PE Children under age 19 Medicaid, PE Pregnant Women Medicaid and/or PE Women's Health Medicaid determinations. If you have any questions or need additional information, please contact Kunita Snead at 404-463-6234 or Kunita.snead@dch.ga.gov.

cc: Linda Wiant, Pharm.D, Chief, Medical Assistance Plans
Jonathan Duttweiler, Assistant Chief, Member Services & Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Lucy Smith, Field Operations Director, DHS Office of Family Independence
Kristen Hernandez, Right from the Start Medical Assistance Group Director
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director 2
Barbara Vance, Myers and Stauffer

Revised
3/13/18

Revised
3/13/18



Nathan Deal, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-856-4507 | www.dch.georgia.gov

MEMORANDUM

TO: Dr. Lara Jacobson, Director
Health Promotions, Department of Public Health

FROM: Yvonne Greene, Sr. Manager, Business Operations 
DCH Medicaid Eligibility & Policy

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2018

DATE: February 19, 2018

The purpose of this memorandum is to inform Qualified Providers (QP) of the 2018 Federal Poverty Level (FPL) income limits for Presumptive Eligibility (PE) Medical Assistance. The following FPL and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2018 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. These new income limits should be used for all PE determinations completed by the Department of Public Health effective March 1, 2018.

PE Pregnant Women Medical Assistance (PGW) remains at 220% of the Federal Poverty Level

Budget Group	5% Deduction	220% PGW
1	N/A	N/A
2	69	3,018
3	87	3,810
4	105	4,602
5	123	5,394
6	141	6,186
7	159	6,978
8	177	7,770
9	195	8,562
10	213	9,354
11	231	10,146
12	249	10,938

For each additional person over Budget Group size 12 add \$792

Dr. Lara Jacobson
Page 2
February 19, 2018

PE Women's Health Medical Assistance (WHM) remains at 200% of the Federal Poverty Level

Budget Group	200% WHM
1	2,024
2	2,744
3	3,464
4	4,184
5	4,904
6	5,624
7	6,344
8	7,064
9	7,784
10	8,504
11	9,224
12	9,944

For each additional person over Budget Group size 12 add \$720

Please distribute to all State Office Staff, Supervisors and members of the QP team that process PE Pregnant Women and/or PE Women's Health Medical Assistance determinations. If you have any questions or need additional information, please contact Kunita Snead at 404-463-6234 or Kunita.snead@dch.ga.gov or Lorraine Russell at 404-651-9978 or lrussell2@dch.ga.gov.

cc: Blake Fulenwider, Chief, Medical Assistance Plans
Lynette Rhodes, Associate Chief, Medical Assistance Plans
Jonathan Duttweiler, Assistant Chief, Member Services & Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Jewel McKeever, Field Operations Director, DHS Office of Family Independence
Kristen Hernandez, Right from the Start Medical Assistance Group Director
Malcolm Wells, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director 2
Latoya Osmani, Department of Public Health
Cathy Broom, Department of Public Health
Paula Brown, Department of Public Health
Barbara Vance, Myers and Stauffer


Brian P. Kemp, Governor
Frank W. Berry, Commissioner

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

MEMORANDUM

TO: Carie Summers, VP, Healthcare Financing
 Georgia Hospital Association

FROM: Yvonne Greene, Sr. Manager, Business Operations
 DCH Medicaid Eligibility & Policy

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2019

DATE: February 20, 2019

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2019 Federal Poverty Level (FPL) income limits for Presumptive Eligibility (PE) Medical Assistance. The following FPL and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2019 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. These new income limits should be used for all PE determinations completed by Qualified Hospitals effective March 1, 2019.

Budget Group	5% Deduction	Parent/Caretaker with Children under age 19	133% Children 6-19	149% Children 1-5	205% Children 0-1	220% PGW
1	53	310	1,385	1,551	2,134	N/A
2	71	457	1,875	2,100	2,889	3,101
3	89	551	2,365	2,649	3,644	3,911
4	108	653	2,854	3,198	4,399	4,721
5	126	752	3,344	3,747	5,155	5,532
6	145	826	3,834	4,295	5,910	6,342
7	163	903	4,324	4,844	6,665	7,152
8	181	970	4,814	5,393	7,420	7,963
9	200	1,034	5,304	5,942	8,175	8,773
10	218	1,113	5,794	6,491	8,930	9,583
11	237	1,194	6,284	7,039	9,685	10,394
12	255	1,244	6,774	7,588	10,440	11,204

For each additional person over Budget Group size 12:

Add \$19 (5% Deduction)

Add \$50 (Parent/Caretaker with Children under 19)

Add \$490 (133% FPL)

Add \$549 (149% FPL)

Add \$755 (205% FPL)

Add \$811 (220% FPL)



Carie Summers
Page 2
February 20, 2019

Women's Health Medical Assistance (WHM) remains at 200% of the Federal Poverty Level.

Budget Group	200% WHM
1	2,082
2	2,819
3	3,555
4	4,292
5	5,029
6	5,765
7	6,502
8	7,239
9	7,975
10	8,712
11	9,449
12	10,185

For each additional person over Budget Group size 12 add \$737

Please distribute to all Hospital Staff, Supervisors and members of the QH team that process PE Parent/Caretaker with Children under age 19, PE Children under age 19, PE Pregnant Women and/or PE Women's Health Medical Assistance determinations. If you have any questions or need additional information, please contact Kunita Sned at 404-463-6234 or Kunita.sned@dch.ga.gov.

cc: Lynette Rhodes, Acting Executive Director, Medical Assistance Plans
Jonathan Duttweiler, Director, Member Services & Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, Right from the Start Medical Assistance Group Director
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Melanee Payne, Interim Quality Control Program Director
Stefanie Ashlaw, Director, PeachCare for Kids®
Karen Salter, Myers and Stauffer

Appendix P –Planning for Healthy Babies

P4HB Post Card and Application in English and available in Spanish

Planning for Healthy Babies®

What is the Planning for Healthy Babies (P4HB) Program?

P4HB provides no cost family planning services to eligible women in Georgia. You may be eligible for:

- Family Planning Only
- Inter-pregnancy Care (IPC) - family planning and additional services for women who have delivered a very low birth weight (VLBW) baby. This is a baby weighing less than 3 pounds 5 ounces. You can receive services for 24 months.
- Resource Mother Outreach – A specially trained case manager will help women, already receiving Medicaid, who have delivered a VLBW baby. You can receive services for 24 months.

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, a Resource Mother and more.

Who is eligible?

- Women ages 18 through 44 who meet monthly family income limits
- Women who are U.S. citizens and Georgia residents
- Women who have given birth to a baby weighing less than 3 pounds, 5 ounces (IPC/Resource Mother component).



Be Smart. Plan Before You Start!!!



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

How Do I Apply?

You can apply online through gateway.ga.gov

If you are unable to apply online, applications may be picked up at one of these three locations:

Local Boards of Health
Local Division of Family and Children Services (DFCS) Office
Community Health Centers

Completed applications and required documentation should be faxed or mailed to:

RSM Group
426 West 12th Street
Alma, Georgia 31510
Fax: 912-632-0389

Where can I go for more information?

Visit <https://dch.georgia.gov/planning-healthy-babies> or
call 1-877-427-3224



Planning for
Healthy Babies®

P-1



Application for Health Coverage & Help Paying Costs

Form Approved
OMB No. 0930-1191

THINGS TO



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 **Medical Assistance**.
- 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 gateway.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

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 gateway.ga.gov or call 1-877-423-4746. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- Online:** gateway.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 gateway.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 (Rev. 9/17)

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix			
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number () -		15. Other phone number () -	
16. Do you want to get information about this application by email? ☐ Yes ☐ No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)? _____			

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.



NEED HELP WITH YOUR APPLICATION? Visit gateway.az.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 (Rev. 9/17)

Page 1 of 8

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix _____ 2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy) _____ 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) _____ - _____ - _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](https://www.socialsecurity.gov). TTY users should call 1-800-255-0135.

6. Do you plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES.** If yes, please answer questions a–c. ☐ **NO.** If no, skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No If yes, what is the expected due date ____/____/____; and how many babies are expected? _____

8. Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES.** If yes, answer all the questions below.  ☐ **NO.** If no, SKIP to the Income questions on page 3.  Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. Race (OPTIONAL—check all that apply.)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
			☐ Other _____	

 **NEED HELP WITH YOUR APPLICATION?** Visit [gowv.gov](https://www.gowv.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 (Rev. 9/17)

Page 2 of 8

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**

If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**

Skip to question 28.

☐ **Self-employed**

Skip to question 27.

CURRENT JOB 1:

18. Employer name and address	19. Employer phone number () -
20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly \$ _____	
21. Average hours worked each WEEK _____	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address	23. Employer phone number () -
24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly \$ _____	
25. Average hours worked each WEEK _____	

26. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

27. If self-employed, answer the following questions:

a. Type of work _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? _____

28. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None				
☐ Unemployment	\$ _____	How often? _____	☐ Net farming/fishing	\$ _____ How often? _____
☐ Pensions	\$ _____	How often? _____	☐ Net rental/royalty	\$ _____ How often? _____
☐ Social Security	\$ _____	How often? _____	☐ Other income	\$ _____ How often? _____
☐ Retirement accounts	\$ _____	How often? _____	Type: _____	
☐ Alimony received	\$ _____	How often? _____		

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid	\$ _____	How often? _____	☐ Other deductions	\$ _____	How often? _____
☐ Student loan interest	\$ _____	How often? _____	Type: _____		

30. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person. ➡

Your total income this year \$ _____	Your total income next year (if you think it will be different) \$ _____
---	---

THANKS! This is all we need to know about you.



NEED HELP WITH YOUR APPLICATION? Visit adwvtx.ca.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.

Page 3 of 8

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix _____		2. Relationship to you? _____															
3. Date of birth (mm/dd/yyyy) _____		4. Sex ☐ Male ☐ Female															
5. Social Security number (SSN) _____ We need this if you want health coverage and have an SSN.																	
6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No If no, list address: _____																	
7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.) ☐ YES. If yes, please answer questions a–c. ☐ NO. If no, skip to question c. a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse: _____ b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No If yes, list name(s) of dependents: _____ c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If yes, please list the name of the tax filer: _____ How is PERSON 2 related to the tax filer? _____																	
8. Is PERSON 2 pregnant? ☐ Yes ☐ No If yes, what is the expected due date ____/____/____; and how many babies are expected? _____																	
9. Does PERSON 2 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.) ☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.																	
10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No																	
11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No																	
12. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status? ☐ Yes. Fill in their document type and ID number below. a. Document type _____ b. Document ID number _____ c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No																	
13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No	15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No															
Please answer the following questions if PERSON 2 is under the age of 19. 16. Did PERSON 2 have health insurance and lose it within the past 2 months? ☐ Yes ☐ No a. If yes, end date: _____ b. Reason the insurance ended: _____ 17. Is PERSON 2 a full-time student? ☐ Yes ☐ No 18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____ 19. Race (OPTIONAL—check all that apply.) <table style="width: 100%; border: none;"> <tr> <td>☐ White</td> <td>☐ American Indian or Alaska Native</td> <td>☐ Filipino</td> <td>☐ Vietnamese</td> <td>☐ Guamanian or Chamorro</td> </tr> <tr> <td>☐ Black or African American</td> <td>☐ Asian Indian</td> <td>☐ Japanese</td> <td>☐ Other Asian</td> <td>☐ Samoan</td> </tr> <tr> <td>☐ Chinese</td> <td>☐ Korean</td> <td>☐ Native Hawaiian</td> <td>☐ Other Pacific Islander</td> <td>☐ Other _____</td> </tr> </table>			☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro	☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander	☐ Other _____
☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro													
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan													
☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander	☐ Other _____													

Now, tell us about any income from PERSON 2 on the back.



NEED HELP WITH YOUR APPLICATION? Visit oahs.wv.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 (Rev. 9/17)

Page 4 of 8

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**

If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**

Skip to question 30.

☐ **Self-employed**

Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

() -

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

() -

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

27. Average hours worked each WEEK

28. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$

30. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment

\$

How often?

☐ Pensions

\$

How often?

☐ Social Security

\$

How often?

☐ Retirement accounts

\$

How often?

☐ Alimony received

\$

How often?

☐ Net farming/fishing

\$

How often?

☐ Net rental/royalty

\$

How often?

☐ Other income

\$

How often?

Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid

\$

How often? _____

☐ Other deductions

\$

How often? _____

☐ Student loan interest

\$

How often? _____

Type: _____

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income this year

\$

PERSON 2's total income next year (if you think it will be different)

\$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.



NEED HELP WITH YOUR APPLICATION? Visit getwww.ca.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 946a (Rev. 9/17)

Page 5 of 8

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

- ☐ If No, skip to Step 4.
☐ Yes. If yes, go to Attachment B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

- ☐ YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

- ☐ Medical Assistance _____
☐ Medicare _____
☐ TRICARE (Don't check if you have direct care or Line of Duty)
☐ VA Health Care Programs _____
☐ Peace Corps _____

- ☐ Employer Insurance _____
☐ Name of health insurance: _____
Policy number: _____
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No
☐ Other
Name of health insurance: _____
Policy number: _____
Is this a limited-benefit plan (like a school accident policy)?
☐ Yes ☐ No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

- ☐ YES. If yes, you'll need to complete and include Attachment A.
☐ NO. If no, continue to Step 5.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0930-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: OMB, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



NEED HELP WITH YOUR APPLICATION? Visit gateway.va.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 (Rev. 9/17)

Page 6 of 8

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit gateway.ga.gov or call 1-877-423-4746 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by calling the Georgia Department of Community Health, Office of Inspector General (OIG), Program Integrity Section at 404-463-7590 or toll free at 1-800-533-0686.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Agencies, DFCS and the FFM to use income data, including information from tax returns. The Health Insurance Agencies, DFCS and the FFM will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

- ☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medical Assistance

- I am giving to the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical Assistance agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Agencies, DFCS and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS or the FFM that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at 1-877-423-4746. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Attachment C.

Signature	Date (mm/dd/yyyy)
-----------	-------------------



NEED HELP WITH YOUR APPLICATION? Visit gateway.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 (Rev. 9/17)

Page 7 of 8

STEP 6 Mail completed application.

Mail your signed application to the address below:

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

If you want to register to vote, you can complete a voter registration form at www.sos.ga.gov.



NEED HELP WITH YOUR APPLICATION? Visit gateway.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 (Rev. 9/17)

Page 8 of 8

ATTACHMENT A



GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
CMS No. 0908-1191

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?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____

List the names of anyone else who is eligible for coverage from this job. (mm/dd/yyyy)

Name: _____ Name: _____ Name: _____

☐ 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*?	☐ Yes ☐ 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? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly	
16. What change will the employer make for the new plan year (if known)?	
☐ 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 360(c)(2)(C)(i) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit gaahhs.org 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 (W/17)

EMPLOYER COVERAGE TOOL



GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Division of Health Insurance



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Form Approved
OMB No. 0930-1191

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 80 percent of such costs (Section 36B(c)(2)(C)(i) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit gateway.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 (9/17)

ATTACHMENT B



GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name _____ ☐ No	☐ Yes If yes, tribe name _____ ☐ 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?	☐ Yes ☐ 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? ☐ Yes ☐ No	☐ Yes ☐ 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? ☐ Yes ☐ 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: • 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 gaahcwsr.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 (3/17)

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.

Need a Ride?

Georgia Medical Assistance currently contracts with two Non-Emergency Medical Transportation (NEMT) Brokers to arrange NEMT services for eligible Medical Assistance members to and from medical treatments, medical evaluations, obtaining prescriptions from pharmacies and medical equipment. Each NEMT broker covers different regions of the state. Call the broker assigned to the county you live in to schedule non-emergency medical transportation Monday through Friday from 7 a.m. to 6 p.m. You must schedule your transportation at least three days before your appointment date. Locate your county below and contact the assigned broker at the number provided. If you have a question, comment or complaint about NEMT, please call the Member Contact Center toll-free at 1-866-211-0950 for assistance.

Atlanta Region - Southeastrans, toll-free 1-866-388-9844, local 404-209-4000
Assigned Counties: DeKalb, Fulton, and Gwinnett.

North Region - Southeastrans, toll-free 1-866-388-9844, local 678-510-4555
Assigned Counties: 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.

Central Region - Logisticare, toll-free 1-888-224-7981
Assigned Counties: 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 Region - Logisticare, toll-free 1-888-224-7988
Assigned Counties: 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 Region - Logisticare, toll-free 1-888-224-7985
Assigned Counties: 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, Upton, Webster, Wilcox and Worth.



PowerLine:

The PowerLine is a statewide toll-free telephone number that provides health care 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 health care 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 website:

<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&task=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

How to order *Understanding Medical Assistance* booklets:

Web Access

- Go To:

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

Member Information tab and then to the Member Notification tab.



Member Information Tab:

The screenshot displays the GAMMIS (Georgia Adult Medical Management Information System) interface. At the top, there's a navigation bar with the Georgia Department of Community Health logo, the GAMMIS logo, and a search bar. Below this is a secondary navigation bar with links like Home, Contact Information, Member Information (highlighted), Provider Information, etc. The main content area shows a 'User Information' section with a 'Login/Manage Account' button. Below that, there's a 'PDF Reader Required' notice and a 'File Download Issues' section. The primary content is a table titled 'Member Notices (10 rows returned)' with columns for Title, File Type, Size (KB), and Release Date. The table lists various notices, including 'Understanding Medical Assistance', 'Georgia Families Frequently Asked Questions and Answers - Members', and 'Home and Community Service Booklet 2016'. At the bottom, there's a footer with language options, accessibility links, and a 'REPORT FRAUD' button.

Title	File Type	Size (KB)	Release Date
Understanding Medical Assistance	PDF	67.1 KB	10/13/2017
Georgia Families Frequently Asked Questions and Answers - Members	PDF	445.5	09/06/2017
1095-B Important Notice	PDF	74.4	01/29/2019
Home and Community Service Booklet 2016	PDF	2449.7	01/21/2019
Home and Community Service Booklet 2014	PDF	467.3	03/21/2014
New Co-Payments for Peachcare for Kids	PDF	98.5	02/21/2012
Form 5459 - Member's Release of Information	PDF	29.3	03/09/2011
Fullard Review Submission Package	PDF	32.3	03/09/2011
Home and Community Service Booklet	PDF	8686.1	10/27/2010
Health Check Brochure	PDF	1090.3	10/26/2010

Web Print

You may print the booklet from the web at the address below:

https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/MEMBER%20NOTICES/medical%20assistance%20plans%20booklet%20%20final_e%2020171003130824.pdf



DMA 292 (Request for Forms)

- Download form DMA 292 from the web:

Home | Contact Information | Member Information | **Provider Information** | Provider Enrollment | Nurse Aide | EDI | Pharmacy
Home | Provider Notices | Provider Manuals | Provider Messages | Fee Schedules | **Forms** | PASRR Request | TPL Carriers | FAQ for Providers
Web Portal Training | Provider Education

User Information ? a
Login/Manage Account Login

PDF Reader Required
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.](#)

File Download Issues
Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. [Click here for help with download issues.](#)

ALL FORMS

Forms (57 rows returned)			
Title	Category	Size (KB)	Release Date
DMA-632: Elig. Determination for Pregnancy Related Care	ALL FORMS	23.80	01/10/2011
NPI 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	02/18/2011
DMA-292: Download for Forms or Handbooks	ALL FORMS	73.50	03/01/2011



Mail DMA 292 Form

- Mail form DMA 292 to:

DXC Technology
P. O. box 105209
Tucker, GA 30085-5209

DXC Technology will ship within five (5) business days. Order any quantity you need; each box can contain 400 booklets maximum.



Ordering, Prescribing and Referring

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medical Assistance beneficiaries to be enrolled in the Georgia Medical Assistance Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b) (18) C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medical Assistance as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medical Assistance claim is associated with a provider who is not enrolled in the Georgia Medical Assistance program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by the policy will begin to deny.

For the NEW CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provides information that is now used to transmit OPR information.

NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA ☐		PICA ☐	
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA (B/L) LUNG ☐ OTHER ☐		1a. INSURED'S LD. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		CITY STATE	
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐		CITY STATE	
8. RESERVED FOR NUCC USE		ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO:		12. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐		b. OTHER CLAIM ID (Designated by NUCC)	
b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) ()		c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. OTHER ACCIDENT? YES ☐ NO ☐		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, complete items 9, 9a, and 9d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
10d. CLAIM CODES (Designated by NUCC)		SIGNED _____ DATE _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
15. OTHER DATE MM DD YY QUAL. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate to service line below (24E) ICD Ind. _____		23. PRIOR AUTHORIZATION NUMBER _____	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPDIT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1			
2			
3			
4			
5			
6			
25. FEDERAL TAX ID. NUMBER SSN EIN ☐ ☐		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES ☐ NO ☐ (For govts. clinics, see back)	
28. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____ 30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED _____ DATE _____		a. NPI b. _____	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

The following table outlines the **revised changes** to the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added “(NUCC)” after “APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE.”
Header	Replaced “08/05” with “02/12”
Item Number 1	Changed “TRICARE CHAMPUS” to “TRICARE” and changed” (Sponsor’s SSN)” to “(ID#/DoD#).”
Item Number 1	Changed “(SSN or ID)” to “(ID#)” under “GROUP HEALTH PLAN”
Item Number 1	Changed “(SSN)” to “(ID#)” under “FECA BLK LUNG.”
Item Number 1	Changed “(ID)” to “(ID#)” under “OTHER.”
Item Number 8	Deleted “PATIENT STATUS” and content of the field. Changed title to “ RESERVED FOR NUCC USE. ”
Item Number 9b	Deleted “OTHER INSURED’s DATE OF BIRTH, SEX.” Changed title to “ RESERVED FOR NUCC USE. ”
Item Number 9c	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “ RESERVED FOR NUCC USE. ”
Item Number 10d	Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).” Field 10d is being changed to receive Worker’s Compensation codes or Condition codes approved by NUCC. FOR DCH/HP: FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “OTHER CLAIM ID (Designated by NUCC).” Added a dotted line on the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed “If yes, return to and complete Item 9 a-d” to “If yes, complete items 9, 9a, and 9d.” (Is there another Health Benefit Plan?)
Item Number 14	Changed title to “DATE OF CURRENT ILLNESS, INJURY, and OR PREGNANCY (LMP).” Removed the arrow and text on the right-hand side of the field. Added “QUAL.” with a dotted line to accommodate a 3-byte qualifier.” FOR DCH/HP: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).
Item Number 15	Changed title from ‘IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE the FIRST DATE’ to “OTHER DATE.” Added “QUALIFIER.” with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date]); 091 (Report End [Relinquished Care Date]); 444 (First Visit or Consultation).

Item Number 17	Added a dotted line on the left-hand side of the field to accommodate a 2-byte qualifier – Used by Medicare for identifiers for provider roles: Ordering, Referring and Supervising. FOR DCH/HP: Use the following Ordering Provider, Referring, Supervising Qualifiers (effective 4/01/2014): Ordering = DK; Referring = DN or Supervising = DQ.
Item Number 19	Changed title from “ RESERVED FOR LOCAL USE ” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).” FOR DCH/HP: Remove the Health Check logic from field 19 and add it in field 24H .
Item Number 21	Changed instruction after the title (Diagnosis or Nature of Illness or Injury) from “(Relate Items 1, 2, 3 or 4 to Item 24E by Line)” to “Relate A-L to service line below (24E).”
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added “ICD Indicator.” and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. Diagnosis Code ICD Indicator - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. (Do not bill ICD 10 code sets before January 1, 2016.)
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from “MEDICAL ASSISTANCERESUBMISSION” to “RESUBMISSION.” The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F FOR DCH/HP: Item numbers 24A & 24G are used to capture Hemophilia drug units. 24H (EPSDT/Family Planning).
Item Number 30	Deleted “BALANCED DUE.” Changed title to “ RESERVED FOR NUCC USE. ”
Footer	Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”