

PART II

POLICIES AND PROCEDURES
AFFORDABLE CARE ACT FOR
PRESUMPTIVE ELIGIBILITY
PREGNANT WOMEN



GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE PLANS

Revised: July 1, 2019

Policy Revisions Record
Part II Policies and Procedures Manual for
Presumptive Eligibility Pregnant Women 2019

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION (Revision required by Regulation, Legislation, etc.)
			A=Added D=Deleted M=Modified	
1/1/19	Footer	Updated revised date	M	
1/1/19	201	Removed 'Declaration of Citizenship'	D	
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1/1/19	205	Updated 'year' in title and training schedule	M	
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1/1/19	305	Removed procedure about medically verified	D	
1/1/19	306	Added phone #	A	
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1/1/19	502	Updated procedures	M	
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1/1/19	Appendix F	Removed Declaration of Citizenship form 216 (English & Spanish)	D	
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4/1/19	603	Updated effective date for income limit chart	M	
4/1/19	603	Removed 2018 income limit chart	D	
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Policy Revisions Record Part II
Policies and Procedures Manual for
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4/1/19	Appendix I	Added statement to look for 'MAGI' of 'FM'	A	
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7/1/19	401	Added procedure for Inmate Medicaid	A	

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PRESUMPTIVE ELIGIBILITY PREGNANT
WOMEN
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CHAPTER 100 INTRODUCTION

101 Goal of Presumptive Eligibility (PE)

The goal of the Presumptive Eligibility (PE) program is to provide Medical Assistance coverage during the application processing period and remove barriers to the availability of prenatal care critical in positively affecting the birth outcome and the health of the mother.

The Department of Community Health (DCH) is committed to providing the individuals responsible for determining Pregnant Women PE with clear and practical guidelines:

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

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

CHAPTER 200 OVERVIEW OF PRESUMPTIVE ELIGIBILITY

201 Definition and Description of Presumptive Eligibility (PE)

§435.907 Application/SPA S28-2; S28-3; S28-4; S94-1

The federal legislation, which gives states the authority to cover pregnant women, infants and children under federal poverty level income limits, also contains a provision for providing ambulatory prenatal care to pregnant women during the time-period that a formal Medical Assistance application is pending with the eligibility agency. Beginning January 1, 1993, the Division of Medical Assistance (DMA), a division within the Department of Community Health (DCH), implemented this Presumptive Eligibility (PE) program for pregnant women.

PE is a determination performed by the Qualified Provider (QP)/Qualified Hospital (QH). Coverage is available prior to a formal determination of eligibility by the Right from the Start Medical Assistance Group (RSM) or the Division of Family and Children Services (DFCS) office.

PE is an expedited process of enrolling eligible pregnant applicants in the Medical Assistance program. It allows certain providers, designated as a QP/QH, to make a preliminary Medical Assistance eligibility determination on behalf of a pregnant applicant. Medical Assistance coverage may be granted to the pregnant applicant whose net taxable income does not exceed 220% of the federal poverty level. PE consists of an income comparison test using the applicant's statements to establish gross MAGI-based income and pregnancy.

PE period begins on the date the QP/QH determines the applicant eligible. PE ends when RSM or DFCS determines eligibility or ineligibility for Medical Assistance, but no later than at the end of the following month of the PE approval. PE Medical Assistance does not cover inpatient hospital and delivery services, only ambulatory prenatal care services are covered during the PE period.

If the applicant is determined eligible for the program, she receives a temporary Medical Assistance certificate to show eligibility. If the eligibility continues, she receives the plastic Medical Assistance member identification card. If a member was previously issued a Medical Assistance member identification card, she will not automatically be mailed a replacement card. Replacement cards are requested by the member via online through

GAMMIS or by calling DXC Technology at 1-866-211-0950.

After the PE process is completed, the QP/QH will obtain a signed, Single Streamlined Medical Assistance application, form 94a; HIPAA, form 5460 and Notice of Action (Approval/Denial), form 634. These forms, along with a copy of the PE application form 632, will be forwarded to the RSM or DFCS office for a formal determination of Medical Assistance eligibility.

Procedures for routing forms and communicating information between the QP/QH and the local RSM or DFCS office should be worked out at the county level.

The completed PE Pregnant Women packet must be received at the RSM or DFCS office within five (5) business days after the PE application is taken. If at all possible, the PE Packet should be forwarded to the RSM or DFCS office daily to assure a fast turnaround on the formal application. The later in the pregnancy the applicant is, the more critical expedient application processing becomes.

202 Summary of Process

The PE process involves the QP/QH, DCH, the Georgia Medicaid Management Information System (GAMMIS), and the RSM or DFCS office. The QP/QH determines eligibility for the presumptive period, the RSM or DFCS office determines eligibility for ongoing and retroactive Medical Assistance and DCH/GAMMIS issues the Medical Assistance member identification card, thereby, providing 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 coverage. The QP/QH obtains enough information to determine income and pregnancy eligibility based on the applicant's statements. After the PE Pregnant Women Medical Assistance determination is completed, the QP/QH assists the applicant with the Single Streamlined Medical Assistance application, form 94a for ongoing and retroactive Medical Assistance eligibility.

After the PE Pregnant Women Medical Assistance is approved, the applicant is given a temporary Medical Assistance certificate and notice of approval, form 634. The QP/QH sends the completed PE Pregnant Women packet to the local RSM or DFCS office.

Upon receipt of the completed PE package, the local RSM or DFCS office registers the Medical Assistance application and determines eligibility for ongoing months, as well as, the retroactive months. Notice is given to the applicant regarding the eligibility finding, and the results of the determination are forwarded to the DCH/GAMMIS for appropriate processing.

When DCH/GAMMIS receives the eligibility information, an open record is established on the history file (member data base) for payment of claims. When the DCH/GAMMIS is notified by the local RSM or DFCS office of the results of the Medical Assistance determination, the record is continued as an active Medical Assistance record if eligible or closed if ineligible. Subsequent changes of address should be reported by the applicant to the DFCS Call Center at 1-877-423-4746 or online at www.gateway.ga.gov. Loss of the Medical Assistance card, should be reported by the applicant to the DXC Technology Member Contact Center at 1-866-211-0950.

203 Certification Process and Liability

Providers who meet the requirements of participation will be given the opportunity to become Qualified Providers/Qualified Hospitals. 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 should contact:

DXC Technology Provider Enrollment

P.O. Box 105201

Tucker, GA 30085-5201

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

Enrollment Wizard

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

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

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

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

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

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

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

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

[Provider Enrollment Application](#)

204 Responsibilities of a Qualified Provider/Qualified Hospital

- Make correct determinations of PE;
- Notify RSM or DFCS office within 5 business days of PE determination results (preference is daily);
- Inform the applicant in writing of the results of the PE determination;
- After the completion of the PE determination, obtains a signed 94a.

DCH Member Services and Policy Unit will be used in support of activities to provide follow-up training to providers who are in need of additional training. Additionally, this staff will review a sample of PE applications, form 632, monthly; to identify areas of the procedural process needing modification.

205 2019 PE Pregnancy VICS Training Schedule

New worker training will be held every quarter. New workers are required to attend one training, via live session. New workers are required to attend the all staff refresher training also. PE Coordinators should email Kunita Snead at Kunita.snead@dch.ga.gov with names and preferred date for new workers.

New Worker Training

Training will be held on the following dates from 9:30 am – 3:30 pm via Telehealth.

February 6, 2019

May 8, 2019

August 14, 2019

November 6, 2019

All Staff Refresher Training

Mandatory training will be held on the following date from 9:30 am – 12:30 pm via Telehealth.

June 12, 2019

All state QPs agencies such as Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) and Q H s 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 Kunita Snead at Kunita.snead@dch.ga.gov to make arrangements to attend the training at the DCH State office in Atlanta.

New workers should have some basic knowledge of PE Pregnant Women before participating in training which includes, but not limited to:

- PE Pregnant Women manual review
- PE Pregnant Women forms review
- The PE Pregnant Women process or procedures for your office
- Non-financial eligibility criteria (Citizenship/Immigration status; residency)
- Financial eligibility criteria (Income; deductions; FPL)
- Basic Budget Groups understanding
- Basic P4HB understanding

206 Services and Provider Population

PE provides Medical Assistance reimbursement for ambulatory prenatal care during the application processing period. A healthy outcome to pregnancy is affected by many factors including regular prenatal care and continuing good health of the pregnant woman; PE does not cover inpatient hospital and delivery services. Inpatient hospital services, and delivery procedures, are not included because they do not meet the definition of ambulatory prenatal care services as defined in the Medical Assistance state plan.

For dental coverage, applicant should be given DMA 635 form, *Attestation of Pregnancy* to have her doctor complete. Applicant should then provide the completed form to her dentist. Only limited services are covered.

Note: Dental coverage ends the day pregnancy is terminated.

All limitations to services and other special requirements, such as prior approval, must be met for the service to be reimbursable. Claims must be submitted according to the directions of DCH policy within the time frames specified. Any questions regarding billing procedures should be directed to the DCH's fiscal agent, DXC Technology.

While only certain providers can be certified as Qualified Providers/Qualified Hospitals, any enrolled provider may render service and seek reimbursement from DCH approved services rendered during the PE period. By allowing all enrolled providers to give services during

the PE period, the goal of improving health care availability is met.

Pharmacy updates take 24-48 hours to update in the GAMMIS system. For emergency updates, PE Coordinators should send a request to pecorrections@dch.ga.gov the same day of the PE approval (send member's first name, last name and Medical Assistance ID#).

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 application may be made at any time during a pregnancy, even if there is a Medical Assistance application pending at the county DFCS office. However, a PE application cannot be taken after the pregnancy has ended.

If the applicant is already active on another Medical Assistance Class of Assistance (COA), inform the applicant she is already active. Refer her to the DFCS office to have her case updated with her pregnancy information. PE is temporary Medical Assistance; therefore, do not complete a PE application when the applicant is already active on full Medical Assistance except for Planning for Healthy Babies® (P4HB) (aid categories 180-Inter-Pregnancy Care or 181-Family Planning). Refer to appendix C for a brief overview of the COA.

If the applicant is active on P4HB (180-181), complete the PE application, add PE eligibility to GAMMIS, complete the *PE Manual Updates* form to indicate 'Terminate P4HB' and email form along with 632 to DCH at pecorrections@dch.ga.gov.

Members active on Women's Health Medical Assistance (WHM) aid category 245, please inform them to contact their MORROW caseworker to report pregnancy or send email to MORROW at womenshealth@dch.ga.gov.

If applicant is active on SSI, QP should complete the *SSI Pregnant Women Update* form and send to MORROW RSM by fax at 770-960-2061 or by email at womenshealth@dch.ga.gov.

All other active Medical Assistance members should report their pregnancy information to DFCS in person at the local office, online at www.gateway.ga.gov or call 1-877-423-4746.

Note: Individuals who are inmates of a public institution are not eligible for PE Medical Assistance. Do not complete a PE application.

The applicant is the primary source of information regarding PE. 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. The applicant's statement regarding pregnancy is all that is required. Under the Affordable Care Act (ACA) medical verification cannot be required prior to processing the PE application.

PE policy does not allow for Emergency Medical Assistance (EMA) to be approved as PE. An applicant may not be screened out if they are not a United States citizen; have not been naturalized; have not resided in the United States for at least 5 years per the Department of Homeland Security (DHS). These applicants will be given an application form 632 and informed that their PE application will be denied initially; however, the Single Streamlined Medical Assistance Application 94a will be reviewed by the RSM or DFCS 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, and may not be disclosed to any persons or agencies other than those directly related to the administration of Medicaid known as covered entities.

DCH, RSM, DFCS, QP/QH and 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 104-109](#)) and safeguarding Protected Health Information (PHI) must be enforced at all times.

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

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

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

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

Each applicant will receive the Notice of Privacy Practices Form 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 subjected to discrimination.

304 Notice and Informing

§435.913 Notice of agency's decision concerning eligibility.

An applicant is entitled to adequate notice of the results of the PE determination. She must receive notice, form 634 (approval or denial). Applicant must be informed that her Medical Assistance application has been forwarded to the RSM or DFCS office for a formal determination of eligibility.

Follow the process lined out in Chapter 700 and Appendix F for approvals or denials forms.

305 Fair Hearing Rights

§431.205 Provision of hearing system.

An applicant is entitled to a fair hearing when the RSM or DFCS office makes a decision on her 94a application, for ongoing and/or retroactive Medical Assistance benefits.

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

Per the ACA, a pregnant applicant may only be determined for PE Pregnant Women Medical Assistance once per pregnancy. If the applicant has already been determined eligible for PE Pregnant Women Medical Assistance during her same pregnancy, the QP/QH must deny the new PE Pregnant Women application and forward the PE Pregnant Women packet

to RSM or DFCS.

Time Limits for Pregnant Women	Description
Pregnant Women, because a pregnant woman can potentially have a miscarriage and conceive again before the end of 12 months.	Pregnant women may receive presumptive eligibility, once per pregnancy.

306 Planning for Healthy Babies® (P4HB)

The Planning for Healthy Babies® (P4HB) demonstration covers Family Planning services to women ages 18 through 44 who are at or below 211 percent of the federal poverty level (FPL), and who are U.S. Citizens and Georgia residents. There are three levels of service under P4HB – Family Planning Services, Inter-Pregnancy Care Services, and Resource Mother Services. 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) (birth weight less than 3 pounds 5 ounces) as of January 1, 2011. Women, actively receiving Medical Assistance, that have delivered a VLBW baby, may receive services in the Resource Mother (RM) component of P4HB.

The primary goals of the P4HB program are to reduce: Georgia's low birth weight (birth weight less than 5 pounds 8 ounces) and very low birth weight (birth weight less than 3 pounds 5 ounces) rates; the number of unintended and high-risk pregnancies in Georgia; and Georgia's Medicaid costs by reducing the number of unintended pregnancies.

All applicants for PE Medical Assistance should be informed about P4HB regardless if they are approved or denied. Applicants can apply for P4HB online at www.gateway.ga.gov. Applications can be picked up at a local Health Department, local DFCS office or a local Community Health Center. Completed applications and required documentation should be faxed or mailed to:

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

For more information about P4HB, visit <https://dch.georgia.gov/planning-healthy-babies> or call 1-877-427-3224 or 1-877-423-4746.

See P4HB post card located in Appendix R.

CHAPTER 400 APPLICATION AND ENROLLMENT PROCESS

401 Procedural Responsibilities of Qualified Providers (QP)/Qualified Hospitals (QH)

§435.1103 Presumptive eligibility for other individuals/SPA S94-1; S28-1; S28-2; S28-3; S28-4

The PE process involves several steps from the point of application with the QP/QH through the final disposition of the applicant's Single Streamlined Medical Assistance application (94a) by the RSM or DFCS office.

1. The QP/QH shall conduct an interview with the applicant.
2. Screen applicant in GAMMIS to verify if applicant is already active on Medical Assistance or not and to get known Medical Assistance ID #.
3. If applicant is **NOT** active, complete the PE application (632), other required forms including 94a and determine if applicant is eligible or ineligible.
 - A. If applicant is **eligible**, enter PE in GAMMIS, inform applicant about PE period and 94a will be sent to DFCS or RSM for a full determination. Provide applicant with approval notice (634), Temporary Medical Assistance Certificate, *Quick Guide on PE Pregnant Women*, *Understanding Medical Assistance* booklet and P4HB information.
 - B. If applicant is **ineligible**, inform applicant if her circumstances changes, she can reapply for PE and 94a will be sent to DFCS or RSM for a full determination. Provide applicant with denial notice (634) and P4HB information.
4. If applicant is **ACTIVE**, check aid category,
 - A. If aid category is P4HB (180 or 181), then:
 - i. Start at step 3 above and complete PE Manual Update form, check box for 'Terminate P4HB'
 - ii. Follow the PE Manual Update procedure (see section 702.1)
 - B. If aid category is WHM (245), then:
 - i. Inform applicant to contact their Morrow RSM caseworker to

report pregnancy or QH/QP should send email to womenshealth@dch.ga.gov about applicant's pregnancy information.

C. If aid category is SSI (300-499), then:

- i. Complete the *SSI Pregnant Women Update* form and send completed form to Morrow RSM at womenshealth@dch.ga.gov or 770-960-2061.

D. If aid category is Q-track (660, 661, 662 or 664), then:

- i. Start at step 3 above and send PE Packet to Kunita Snead also at Kunita.snead@dch.ga.gov or 470-386-6272.

E. If aid category is Inmate (815), then:

- i. Complete 632 and all other required forms to determine if applicant is eligible or ineligible (ask applicant for release date)
- ii. **DO NOT** enter PE in GAMMIS
- iii. Send PE packet to Kunita Snead at Kunita.snead@dch.ga.gov or 470-386-6272 (do not sent to RSM/DFCS)
- iv. DCH will enter approved PE in GAMMIS and send application to RSM/DFCS for processing

5. If applicant is Approved, but later discovers she is not pregnant, send an email to DCH at pecorrections@dch.ga.gov to terminate PE in GAMMIS.

Subject of email: Terminate PE-not pregnant

Body of email: Please terminate PE for [Member's name], [Medical Assistance ID #] (attach pregnancy test results).

6. If a member was previously approved for PE and comes back to your office stating their Medical Assistance coverage ended, then follow the steps below:
 - a. Screen member in GAMMIS to see when the PE Medical Assistance coverage ended
 - b. If member applied in your office, search to see if you can locate the PE application

- c. If you locate the PE application, send email to Kunita Snead at Kunita.snead@dch.ga.gov

Subject of email: PGW full MA not processed

Body of email: Give description of what happened. Attach PE application.

- d. If member did not apply in your office or you can not locate the PE application, follow step c above, except attaching PE application.

APPROVED PE MEMBERS REPORTED CHANGES

For any certified presumptively eligible member who needs to report a change (ex. Address, phone #, etc.), the QP/QH shall complete the *PE Manual Updates* form and send to DCH along with the 632.

Correct addresses are needed so members can obtain Medical Assistance notifications and cards, their Care Management Organization (CMO) choice selection and ongoing information, and for NET (non-emergency transportation), etc.

Approved PE members will be required to choose a CMO (WellCare, Amerigroup, CareSource or Peach State) if approved for ongoing and/or retroactive Medical Assistance benefits. Inform them to talk to their providers regarding which Medical Assistance they accept so they know which CMO to choose. QP/QH should clearly go over this information.

CHAPTER 500 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

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

501 Determination of Budget Group

Non-income requirements for PE include the Declaration of Citizenship/Immigration Status; Georgia Residency; and pregnancy statement.

In order to determine income eligibility for PE Medical Assistance coverage, it is necessary to determine who is included in the budget group. The budget group is comprised of those members of the household whose needs and Modified Adjusted Gross Income (MAGI) are included and compared to the Federal Poverty Level (FPL) income limit. The budget group size determines the income limit used and how much MAGI income is used in the comparison to the income limit.

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

Definitions

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

MEMBER- an individual who has been determined eligible and is currently receiving Medical Assistance.

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

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

PARENT- natural, adoptive or step.

CARETAKER RELATIVE– any non-parent adult that a child is living with and who assumes primary responsibility for the dependent child's care (as may, but is not required to, be indicated by claiming the child as a tax

dependent for Federal income tax purposes).

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

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

SIBLING- natural, adoptive or step.

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

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

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

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

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

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

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

Three (3) exceptions for claimed tax dependents:

- Individual(s) being claimed as a tax dependent by someone other than a parent; or
- Child(ren) living with both parents, expected to be claimed by only one parent as a tax dependent and the parents are not filing a joint tax return; or
- Child(ren) claimed as a tax dependent by a non-custodial parent. A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or if there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

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

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

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

Pregnant Woman– each expected child is included in the budget group for PE Medicaid; pregnancy, and number of expected children, is based on the applicant's statement only. Only Pregnant Women and Presumptive Eligible (PE) Pregnant Women Medical Assistance allow multiple expected births to be included without medical verification of the number expected. All other Modified Adjusted Gross Income (MAGI) COAs need medical verification of multiple births; otherwise count a pregnant woman in the budget group as two (her and one unborn child).

502 Citizenship/Immigration Status

§435.406 Citizenship and alienage

Policy

Citizenship/Immigrant status requirements are part of the PE program. Only Citizens/Nationals of the United States and Qualified Immigrants may qualify for PE Medical Assistance. 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. Lawful permanent residents
 - b. Asylees, refugees, Cuban/Haitian entrants, immigrants granted parole in the U.S. for at least one year, immigrants whose deportation is being withheld, battered immigrants or victims of severe form of trafficking
 - 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. Lawful permanent residents for 5 or more years (beginning from date of entry)
 - b. Asylees, refugees, Cuban/Haitian entrants, immigrants granted parole in the U.S. for at least one year, immigrants whose deportation is being withheld, battered immigrants or victims of severe form of trafficking
 - c. Lawful permanent residents with 40 qualifying 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.
 - d. Honorably discharged U.S. Veterans or active duty military personnel, their spouses, or unmarried dependent children.

Procedures

QP/QH must have all applicants declare citizenship/immigration status by checking 'Yes' or 'No', read *Sworn Statement* and sign the PE application. As with income, the applicant's statement of citizenship/immigration 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 RSM or DFCS office with the PE packet.

Acceptable identity and/or citizenship documents:

[§435.407 Types of acceptable documentary evidence of citizenship](#)

No Identity Required on these Citizenship Verifications:

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

Identity Required with these Citizenship Verifications:

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

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

Acceptable Verification of Identity:

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

Applicants should not be denied PE, or the right to apply for the program, because they cannot provide proof of citizenship/immigration status. The application should be denied when they indicate that they are not a U.S. Citizen/Naturalized or not a qualified immigrant. An affirmative entry on the PE application (632) meets the criteria for citizenship/immigration status. If applicant declares 'Yes' for citizenship/immigration status, the applicant will be determined presumptively eligible, provided they are pregnant (per applicant's statement); the budget group's MAGI income is at or below 220% of the FPL income limit; and they are GA residents.

The approved and denied PE applications will be reviewed by the RSM/DFCS team to make a full Medical Assistance determination.

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 RSM/DFCS office. RSM/DFCS will make a full determination for Emergency Medical Assistance (EMA). EMA cannot be completed in PE. QP/QH will follow the procedures outlined in Chapter 703.

The applicant must be afforded the full opportunity to apply for PE Medical Assistance. This means all forms normally given during the course of the application process must be completed. The applicant cannot be given just the form 94a to complete and denied in the event she does not meet the citizenship/immigration status requirements.

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

Copies of the form 94a, in English and Spanish, are contained in Appendix F. Copies of the 94a can be obtained through DFCS/RSM. Ample copies should be kept on hand.

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 and 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

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

Income is money received by the budget unit from any source. Money received may be earned or unearned. Earned income is compensation received in exchange for services rendered. It may be in the form of wages, salaries, commissions, or self-employment. Unearned income is money received for reasons other than for services rendered. It may be in the form of pensions, Social Security (RSDI) benefits, or interest payments. MAGI-based income like taxable income, Social Security benefits, tax-exempt interest and foreign earned income are used in the PE Pregnant Women budget.

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. Deductions are calculated with the same conversion factor below.

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

602 Non-Taxable Income

There are some income types that are not included in the determination of eligibility because they have been defined as non-taxable income and are excluded under federal statute. Some examples of excluded income are adoption assistance payments, TANF (formerly AFDC) benefits, earnings from the Census Bureau, disaster relief assistance, earned income tax credits, energy assistance payments, child support and VA.

If the tax dependent/child has no other source of income and resides with a parent (biological, step, adopted), the Social Security RSDI income is excluded. RSDI of a tax dependent/child is countable only if the tax dependent/child has OTHER income that meets the IRS tax filing threshold for tax dependents or if the child does not reside with a parent and is not claimed as a tax dependent by his or her parent.

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

603 Income Eligibility Limits

Income limits for PE Pregnant Women Medical Assistance are based on 220% of the federal poverty level. The income limit used is determined by the number of people included in the budget group.

PE Pregnant Women 220% FPL Effective 3/1/19

Budget Group	5% Deduction	220% FPL
1	N/A	N/A
2	71	3,101
3	89	3,911
4	108	4,721
5	126	5,532
6	145	6,342
7	163	7,152
8	181	7,963
9	200	8,773
10	218	9,583
11	237	10,394
12	255	11,204

For each additional person over budget group size 12:

Add \$19 (5% Deduction)

Add \$811 (220% FPL)

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

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

604 Determination of MAGI-based Income

Unless specifically exempt or otherwise excluded from consideration, all MAGI-based income of the budget group must be counted in the PE Pregnancy Medical Assistance determination.

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

The three allowable deductions are:

- Pre-tax deductions
- 1040 deductions
- 5% FPL deduction (only use if needed to make individual(s) eligible)

Note: MAGI-based income of the applicant's child, who is under the age of 19, is excluded, if they are not required to file a tax return. Filing for a tax refund is not the same as filing a tax return.

Pre-tax Deductions:

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

22222		a Employee's social security number		OMB No. 1545-0008	
b Employer identification number (EIN)			1 Wages, tips, other compensation		2 Federal income tax withheld
c Employer's name, address, and ZIP code			3 Social security wages		4 Social security tax withheld
			5 Medicare wages and tips		6 Medicare tax withheld
			7 Social security tips		8 Allocated tips
d Control number			9		10 Dependent care benefits
e Employee's first name and initial Last name Suff.			11 Nonqualified plans		12a
			13 Statutory employee Retirement plan Third-party sick pay		12b
			14 Other		12c
					12d
f Employee's address and ZIP code					
15 State	Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax
					20 Locality name

Form W-2 Wage and Tax Statement
Copy 1—For State, City, or Local Tax Department

2016

Department of the Treasury—Internal Revenue Service

1040 Deductions:

Are located on the IRS Tax Return form 1040:

Adjusted Gross Income	23	Educator expenses	23			
	24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24			
	25	Health savings account deduction. Attach Form 8889	25			
	26	Moving expenses. Attach Form 3903	26			
	27	Deductible part of self-employment tax. Attach Schedule SE	27			
	28	Self-employed SEP, SIMPLE, and qualified plans	28			
	29	Self-employed health insurance deduction	29			
	30	Penalty on early withdrawal of savings	30			
	31a	Alimony paid b Recipient's SSN ►	31a			
	32	IRA deduction	32			
	33	Student loan interest deduction	33			
	34	Tuition and fees. Attach Form 8917	34			
	35	Domestic production activities deduction. Attach Form 8903	35			
	36	Add lines 23 through 35	36			
	37	Subtract line 36 from line 22. This is your adjusted gross income ►	37			

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, compared to the budget group's income limit, consider only the net income. Net income is the total profit from the business and deducting business expenses (those costs directly related to producing the goods or services that are allowable IRS deductions).

The applicant's statement regarding gross income, receipts and costs of doing business, is accepted as establishing the amount of net income to be included in the financial calculation. The applicant may state an amount equal to the net income amount for a stated period.

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

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

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

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

See Appendix I - Income for a chart of Income.

Fluctuating Income

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

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

701 On-Line Procedures

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

702 Approvals

Only information from approved PE Pregnant Women applications can be entered into the GAMMIS system. The completed approved PE application form 632 contains certain data elements that can be entered directly into the GAMMIS system.

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

1. Enter the data in the appropriate fields contained on the PE 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 production of a temporary Medical Assistance certification form. Print out two copies of this document. Give the member a copy of the temporary Medical Assistance certificate and Notice of Action-Approval (634). In addition to serving as a temporary Medical Assistance certification, this document serves as a notice to the member that she is approved for PE Medical Assistance. Instruct the member to present this document to her providers as proof of PE Medical Assistance eligibility.
3. Within five (5) business days or sooner, if possible, forward the PE

packet (PE application and supporting documents) to the RSM or DFCS office. **Note:** When the applicant has a TPL, the DMA 285 form is required to be completed. This is the applicant's agreement to cooperate with TPL during post eligibility if a Medical Assistance application is submitted.

The RSM or DFCS office will review the applicant's eligibility for ongoing and retroactive Medical Assistance if the 94a application is included in the PE packet and prior month(s) coverage was requested.

Retroactive (prior months) Medical Assistance are protected by federal regulations, up to the three (3) prior months of the 94a application can be potentially activated. Retroactive Medical Assistance is not automatically given with every application; it must be requested by the applicant.

PE Medical Assistance does not allow for retroactive coverage to be determined.

Only RSM or DFCS offices are able to complete retroactive Medical Assistance for PE Pregnant Women applicants. The applicant must meet all the eligibility requirements for any month(s) requested and state they have at least one unpaid medical expense for each of the month(s) requested. Proof of the expense is not required.

702.1 PE Manual Updates

Only **approved** PE applications are to be sent to GAMMIS for data entry. The PE Manual Update procedure is to be followed when the QH/QP is unable to add PE to GAMMIS, P4HB needs to be terminated or member's information needs to be updated.

1. Complete the *PE Manual Updates* form (only complete the sections(s) that needs to be updated)
2. Email the form along with the PE application (632) to DCH at pecorrections@dch.ga.gov (make email **High Priority**).
Subject line: PE Manual Update
Note: If name, date of birth, SSN or citizenship needs updating, please send proof of the change if member provides it.
3. Continue to send the PE packets to DFCS or RSM for processing of the full Medical Assistance application (**Do not send the PE packet to DCH**)

****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.**

If the applicant is already known to GAMMIS she will retain her Member ID number; if she is new to GAMMIS, DCH will send you the Member ID number.

703 Denied Applications

When the application is denied, it **cannot** be entered in GAMMIS.

Reasons for denial are:

- 1) The applicant is not a U.S. citizen or qualified immigrant;
- 2) The applicant is not pregnant per her statement;
- 3) The applicant's net income is above 220% of the federal poverty level limit;
- 4) The applicant is not a GA resident;
- 5) Unable to determine, applicant refuses to verbally give tax status information.

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

1. Complete and give the applicant a copy of the form 634, Notice of Action-Denial. In the case of a denial, this is the only form the applicant receives for PE Medical Assistance.

Note: Applicant should still apply for ongoing and/or retroactive Medical Assistance by completing the 94a.

2. Within five (5) business days or sooner, if possible, forward the PE packet to the RSM or DFCS office.

Note: If a 94a application is submitted as part of the PE packet, and the applicant is found ineligible for Medical Assistance, the computer system will send the application to the Federally Facilitated Marketplace (FFM). The applicant will be notified directly by the FFM.

The applicant may find additional FFM information or apply directly for Healthcare coverage at www.healthcare.gov, or they may call the FFM any time at 1-800-318-2596, TTY 1-855-889-4325.

APPENDIX A - QUESTIONS & ANSWERS

1. What forms are needed for PE Medical Assistance?

- PE Application form 632
- HIPAA form 5460

2. Do I need a separate Declaration of Citizenship form 216 if I am using the 94a application?

No, a separate form 216 is not needed. Applicants can declare citizenship/immigration status with the 632 and 94a applications.

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

No, anyone whom requests PE Medical Assistance must be given an application. Not everyone will be approved for PE, but they must be given an application. Declaration of citizenship/immigration status can be declared using the application.

4. What reasons can PE Medical Assistance be denied for?

- Not pregnant
- Not a U.S. Citizen or Qualified Immigrant
- Not at or below the 220% FPL net income limit
- Not a Georgia resident
- Unable to determine, applicant refuses to give verbal tax status information

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

- Inform the applicant they have been approved.
- Explain what PE Medical Assistance is.
- Explain what PE Medical Assistance covers and does not cover.
- Explain what a temporary Medical Assistance certificate is and how they should use it.

- Explain the 94a application will be sent to the RSM or DFCS office for ongoing and/or retroactive Medical Assistance determination.
 - Give the applicant the *Quick Guide on PE Pregnant Women Medical Assistance* and review the information.
 - Inform the member of P4HB.
 - Give them the *Understanding Medical Assistance* booklet.
6. What must I inform the applicant of once denied for PE Medical Assistance?
- Inform the applicant they have been denied, why and if her circumstances changes, she can have another PE determination made.
 - Give them form 634, Notice of Action-Denial and review it with them.
 - Explain the 94a application will be given to the RSM or DFCS office for ongoing and/or retroactive Medical Assistance determination.
 - Inform the applicant about P4HB.
7. If the application is approved can I just have the information manually updated by GAMMIS?

No, If the QP/QH has access to the on-line web portal internet they must enter the application information on-line. This is also how the temporary Medical Assistance certificate will be generated. If the QP/QH does not have access to the on-line internet application, then the approved applications have to be entered by DCH; refer to section 702.1 for more detail.

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 Medical Assistance. If the member is active on Medical Assistance (except P4HB) do not complete a PE application. Refer to section 301 for more detail.

See Appendix C for a list of different types of Medical Assistance.

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

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

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

See Appendix I – Treatment of Income Chart.

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

If an individual is wishing to apply for Medical Assistance, they must be given the right to apply without delay.

13. How do I order forms?

Forms 632, 634 (Approval/Denial), 5460, DMA 285, SSI Pregnant Women Update, PE Manual Updates and *Quick Guide on PE Pregnant Women Medical Assistance* can be printed from the Web.

Form 94a should be obtained through RSM or DFCS.

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

Applicants should contact RSM or DFCS for questions regarding P4HB at 1-877-423-3224 or 1-877-423-4746 or visit online at <https://dch.georgia.gov/planning-healthy-babies>.

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

Qualified Providers 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.

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

Yes, the form 632 is the PE Pregnancy application. An application is needed to apply for PE Medical Assistance.

Adding the information onto the Web is an instant update which allows all providers to see the member's eligibility once it is entered on the Web. This allows the member to obtain immediate medical care which is the purpose of completing PE Medical Assistance.

All providers are required to verify Medical Assistance eligibility via the Web or by calling DXC Technology mainly through the IVR system or by speaking with the DXC Technology Provider Contact Center. Having proof of their eligibility is no longer used to validate their eligibility per House Bill 1234.

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

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

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

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

17. When does time as a Permanent Resident begin?

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

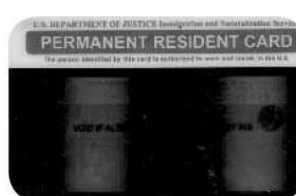
On May 11, 2010, USCIS announced a redesigned Green Card. The Green Card will now be colored green for easy recognition. The Green Card redesign is the latest advance in USCIS's ongoing efforts to deter immigration fraud. State-of-the-art technology incorporated into the new card prevents counterfeiting,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

Sample: This is what the new US green card looks like.

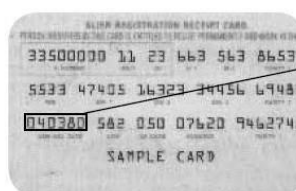


Front

[Back](#)



This card does not have Port-of-Entry on it.



Date you became a Permanent Resident
(April 3, 1980)



Port-of-Entry
or office
where you
were granted
adjustment of
status

Date you became a Permanent Resident
(July 12, 1991)

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.

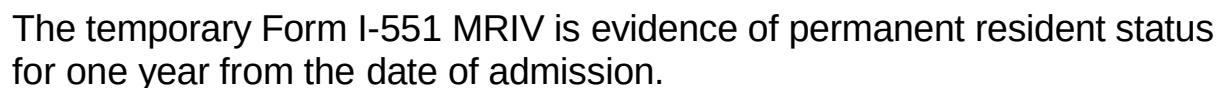
Older U.S. Passport



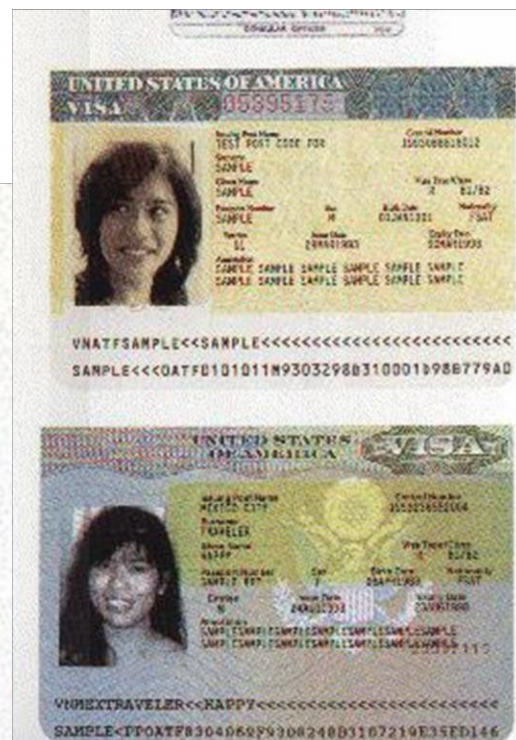
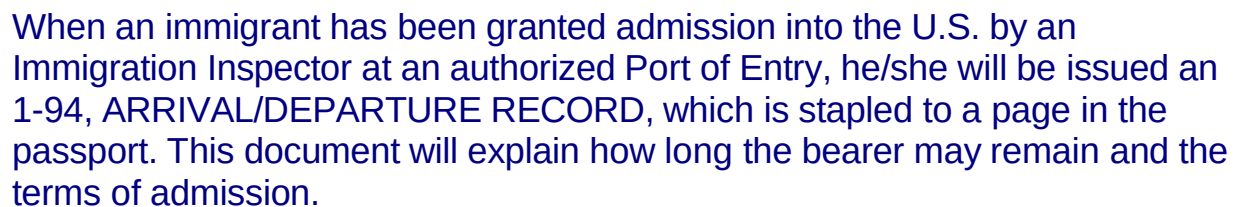
The U.S. Department of State began producing the passport card in July 2008. The passport card is a wallet-size card that can only be used for land and sea travel between the United States and Canada, Mexico, the Caribbean, and Bermuda.



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



Presumptive Eligibility Pregnant Women Revised July 1, 2019



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

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

Student Visa Overview

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

1. F1 Visa: Academic Studies

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

2. J Visa: Academic Studies as an Exchange Visitor

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

3. M Visa: Non-Academic or Vocational Studies

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

Business Visa

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

Work Visa

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

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

Visitor VISA

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

APPENDIX C- CLASS OF ASSISTANCE

Aid Category

Medical Assistance

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 coverage 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 131 - Child Welfare Foster Care	Four Months Extended Medical Assistance because of Spousal Support. Provides 4 months of Medical Assistance coverage for a Parent/Caretaker with Child(ren) Medical Assistance member who has become ineligible because of new or increase spousal support. 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 coverage to a child born to a woman who was eligible for and receiving Medicaid on the day the child was born. A child is eligible for NB 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 138 - PCK/MA DJJ	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. Former PeachCare for Kids members with a DJJ placement Available to children from birth through the last day of the month of the child's 19th birthday.

139 - PCK/MA DJJ/RYDC	Former PeachCare for Kids members with a DJJ/RYDC placement. Available to children from birth through the last day of the month of the child's 19th birthday.
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) provide coverage for children under 19 years of age whose BG income exceeds limits for all Family Medical Assistance COAs and PeachCare for Kids.
148 - Pregnant Woman Medically Needy Spend Down	Family Medical Assistance Medically Needy (FM-MN) provides coverage for pregnant women whose BG income exceeds limits for all Family Medical Assistance COAs 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	Medicaid to eligible children through the month in which the child turns 19 years of age who meet eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).
177 - Family Planning Waiver	The original Family Planning Waiver no longer active
180 - P4HB IPC	Planning for Healthy Babies® IPC
181 - P4HB Family Planning	Planning for Healthy Babies Family Planning Waiver
182 - P4HB Family RM	Resource Mother for Family Medical Assistance beneficiaries
183 - P4HB ABD RM	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 Medicaid 1972 COLA
221 - 222 - 223	ABD Disabled Widow(er) 1984 COLA
224 -225 - 226 Pickle	Pickle (PL 94-566) is a class of assistance (COA) that provides for an individual or couple who correctly received RSDI and SSI or a Mandatory State Supplement (MSS) concurrently and became ineligible for SSI or MSS because of the RSDI COLAs.
227 - 228 - 229 Disabled Adult Child	Disabled Adult Child (PL 99-643) is a class of assistance (COA) that provides 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 Medicaid for an individual whose SSI was terminated because of his/her entitlement to an RSDI disabled widow(er) benefit.
236 - 237- 238	ABD three (3) months prior Medical Assistance
245 Women's Health Medicaid (WHM)	Ongoing WHM for women with breast and/or cervical cancer.
246 GMWD	Georgia Medicaid for Workers with Disabilities (GMWD), offers people with disabilities, who are working, the opportunity to pay a small premium for health care coverage through Medicaid. GMWD provides 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 - Coverage 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 Medical Assistance

All 400 codes	SSI Ex-Parte Medical Assistance
All 500 codes	Refugee Medical Assistance
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 SLMB Limit
790 - 791 - 792 - 793 PeachCare for Kids®	PeachCare for Kids provides medical insurance 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 Medical Assistance	Presumptive WHM for women with breast and/or cervical cancer determined by Qualified Providers/Qualified Hospitals only.
835 Presumptive Newborn	NB Medical Assistance given to deemed newborns by 378 specialty code providers only.
864 Presumptive Pregnant Woman	Presumptive Pregnant Women Medical Assistance for pregnant woman determined by Qualified providers/Qualified hospitals only. (Effective 02/26/15)
865 Presumptive Pregnant Woman 801 Presumptive Parent/Caretaker Adult	Presumptive Pregnant Women Medical Assistance for pregnant woman determined by Qualified Providers/Qualified Hospitals only. (Discontinued 02/26/15) Presumptive Parent/Caretaker Medical Assistance benefits for eligible adults that have a qualifying child.
802 Presumptive Parent/Caretaker Child	Presumptive Parent/Caretaker Medical Assistance benefits for eligible children up to age 19 and the adult(s) who are responsible for those children.
806 Presumptive Child(ren) under 19 Years of Age	Presumptive 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 Foster Care	Continuation of Foster Care Medical Assistance for former foster care members that received coverage while in foster care until they aged out at the age of 18 or older.
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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 on 02/11/XX and will end on the last day of the following month, 3/31/XX.
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 RSM or DFCS determines eligibility or ineligibility for Medical Assistance, but no later than at the end of the following month of the PE approval. *The web portal has been updated and coverage no longer reverts to the beginning of the month for PE.

Budget Group Composition

1. Sally Jones (18) is pregnant with triplets. She lives with her mother and two brothers. Sally's mom expects to claim everyone in the household on her tax return. Sally is applying for Medical Assistance for herself. Who is included in the budget group?

Answer: Sally, unborn triplets, mother and 2 brothers

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

Answer: Marcy, unborn fetus, her husband, her daughter, his son & two mutual children

3. Hope Smith is pregnant with twins. She lives with her boyfriend and her eighteen-year-old son. She is applying for Medical Assistance. Hope doesn't expect to file a tax return. Who is included in the budget group?

Answer: Jane, unborn twins and her son

Income Examples

1. Amber Stone is expecting one child and she lives with her boyfriend Greg and their daughter Amy (2). Amber is unemployed and receives Unemployment Compensation Benefits (UCB) of \$330 per week. Her boyfriend is employed earns \$450 every two weeks. Amy receives SSI of \$120 per month. Amber has no pre-tax or 1040 deductions. Amber nor Greg plan to file taxes. Determine financial eligibility and if Amber will be eligible for PE.

$\$330 \times 4.3333 = \1429.98 – Amber's unearned income

\$1429.98 Total net income

Note: Greg is not included in the BG, therefore his income is excluded also.

Pregnant Women BG of 3 income Limit = \$3,911

Amber is eligible for PE Pregnant Women

2. Ms. Jones is pregnant with triplets. Ms. Jones works 40 hours per week, earns \$28 per hour and is paid every week. She does intend to file taxes. Determine the financial eligibility and if she will be eligible for PE.

$\$28 \times 40 = \$1120 \times 4.3333 = \$4853.29$ – Ms. Jones' earned income

$\$25 \times 4.3333 = \108.33 – Health Insurance

\$4853.29 Ms. Jones' income

\$- 108.33 Health insurance/Pre-tax

\$4744.96 Subtotal net income

\$- 108.00 5% FPL deduction

\$4636.96 Total net income

Pregnant Women BG of 4 income Limit = \$4,721

Ms. Jones is eligible for PE Pregnant Women

3. Susie Thompson (39) is pregnant with twins and lives with her husband Michael and her children, Katie (6) and Pamela (15). Mr. Thompson is employed and earns \$350 every two weeks. The children only receive RSDI of \$450 per month. Mr. Thompson will file taxes jointly with his wife and claim both kids as tax dependents.

$\$350 \times 2.1666 = \758.31 – Mr. Thompson's earned income
\$758.31 Total net income

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

Pregnant Women BG of 6 income Limit = \$6342
Ms. Thompson is eligible for PE Pregnant Women

Appendix F: FORMS Table of Contents

Form Number	Form Name	Revision Date
632 (page 1 & 2)	PE Pregnant Women Medical Assistance Application	01/2019
94a	Single Streamlined Medical Assistance Application (English)	09/2017
94a SP	Single Streamlined Medical Assistance Application (Spanish)	09/2017
634	Notice of Action (Approval)	01/2019
634 (SP)	Notice of Action (Approval) Spanish	01/2019
634	Notice of Action (Denial)	01/2019
634 (SP)	Notice of Action (Denial) Spanish	01/2019
5460	HIPAA (English)	04/2016
5460SP	HIPAA (Spanish)	04/2016
DMA 285	Third Party Liability	01/2006
n/a	Quick Guide on PE Pregnant Women Medical Assistance	01/2019
n/a	Quick Guide on PE Pregnant Women Medical Assistance (Spanish)	01/2019
n/a	PE Manual Updates	01/2019
n/a	SSI Pregnant Women Update	01/2019

PRESUMPTIVE ELIGIBILITY APPLICATION:

The Presumptive Eligibility Application is used to record information needed to determine PE Medical Assistance eligibility.

Completion of Individual Items:

Effective for Services Beginning:	Enter application month; enter the first 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	List her twelve (12) digit number that begins with 111 or 222.
Applicant's Name:	Enter name of applicant.
Applicant's Maiden Name:	Enter Maiden name of applicant if applicable
Applicant's Mailing Address:	Enter mailing address where 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 sent to.
City, State, Zip Code:	Self-explanatory. Must be a GA resident.
County of Residence:	Enter applicant'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.
Health Insurance:	Yes or No.
Tax Filer Household Non-Tax Filer Household:	Enter the filer household per the applicant's statement on what she expects to happen. 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 of the Budget Group. Tax filer households and non-tax filer household budget groups can be very different. *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.
US Citizen or Lawfully Present Immigrant? Y/N	Applicant needs to declare her citizenship/immigration by checking 'Yes' or 'No' if she is a US Citizen/National or Qualified Immigrant.
Monthly Gross Income:	Enter the type of income*: C= Commissions OE = Other Earnings P = Pension S = Self Employed OU= Other Unearned Income W = Wages/Salaries *Refer to Appendix I – Treats of Income Chart. Enter the amount of the income. Enter how often income is received: A = Annually B = Biweekly M = Monthly S = Semi-Monthly W = Weekly Note: Convert all income to a monthly amount.

Monthly Deductions:	Enter all pre-tax and 1040 deductions per budget group member (enter monthly amount).
Monthly Net Income:	Enter net income for each budget group member by subtracting deductions from monthly gross income.
Subtotal Net Income:	Enter monthly total net income for budget group.
Number in Budget Group:	Enter number of persons included in the budget group.
Poverty Income Level:	Enter the amount of the income limit for the budget group size.
5% Deduction:	Enter the 5% deduction based on the budget group size (only use this deduction if needed to make the pregnant woman eligible).
Total Net Income:	Enter the amount remaining after the 5% deduction is subtracted (if needed) from the net income. Compare this amount to the income limit. If the amount is equal to or less than, check the 'eligible' box. If the amount is more, check the 'ineligible' box.
Pregnancy Information:	The provider or designee should assist the applicant to determine her approximate number of weeks pregnant, her expected number of births, and her expected delivery date based on the applicant's statement she is pregnant. No medical verification is requested.
Medical Assistance Application (94a):	Applicant is required to complete the 94a application, so check box next to 'Yes'.
Sworn Statement of Applicant:	Have the applicant read statement and make sure she understands what she is declaring to, sign and date application.

Single Streamlined Medical Assistance Application	The applicant is required to complete the Single Streamlined Medical Assistance application, therefore, check the Yes box. NOTE: The only part of the Single Streamlined Medical Assistance application that is required, after the completion of a PE application, is the applicant's name, contact information, and sign and date the application. All other information was obtained during the PE application process and any other information needed will be obtained during the post eligibility process by RSM/DFCS. The Single Streamlined Medical Assistance application is the point the applicant can request any prior month(s) coverage.
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.
Signature of Individual completing the form:	The provider's signature of the person that completed the PE application.

Page 2 is to add budget group members if additional lines are needed. When Page 2 is used it should be included in the PE Packet.

EFFECTIVE FOR SERVICES

DXC TECHNOLOGY CONTACT CENTER
PHONE: 1-800-766-4456 FAX: 1-866-483-1044BEGINNING _____
MONTH DAY YEAR

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN MEDICAL ASSISTANCE

MEDICAL ASSISTANCE IDENTIFICATION NUMBER _____

APPLICANT'S NAME: _____

MAIDEN NAME: _____

TYPES OF INCOME:
 W - WAGES/SALARIES P - PENSION
 S - SELF EMPLOYMENT U - UNEMPLOYMENT
 OE - OTHER EARNINGS OU - OTHER UNEARNED

APPLICANT'S ADDRESS: _____

TELEPHONE NUMBER: _____

APARTMENT/LOT NUMBER: _____

SOCIAL SECURITY NUMBER: _____
(OPTIONAL)HEALTH INSURANCE: ☐ YES ☐ NO

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

	TAX FILER HOUSEHOLD ☐ YES ☐ NO				DATE OF BIRTH MM/DD/YYYY	GENDER	* RACE	RELATION TO APPLICANT	MONTHLY GROSS INCOME				MONTHLY DEDUCTIONS		MONTHLY NET INCOME
	NON-TAX FILER HOUSEHOLD ☐ YES ☐ NO								TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	PRE-TAX DEDUCTION	1040 DEDUCTION	
	FIRST NAME	MI	LAST NAME	SUFFIX											
01								SELF							
02	Applicant: Are you a US Citizen or Lawfully Present Immigrant? ☐ YES ☐ NO														
03															
04															
05															
06															

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE RIGHT FROM THE START MEDICAL ASSISTANCE (RSM) PROJECT OR THE COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) OFFICE WILL DETERMINE MY CONTINUING ELIGIBILITY WHEN I SUBMIT A FULL MEDICAL ASSISTANCE APPLICATION (94a).

I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IMMIGRANT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY HOUSEHOLD, PREGNANCY, RESIDENCY, TAX STATUS AND INCOME.

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

I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH THE RSM OR DFCS OFFICE MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY, OR NO LATER THAN THE LAST DAY OF THE FOLLOWING MONTH.

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

SUBTOTAL NET INCOME = _____ 5 % FPL DEDUCTION = _____
 NUMBER IN BUDGET GROUP = _____ TOTAL NET INCOME = _____
 POVERTY INCOME LEVEL = _____

APPLICANT IS ☐ ELIGIBLE OR ☐ INELIGIBLE FOR PE PREGNANT WOMEN MEDICAL ASSISTANCE.

THE WOMAN FOR WHOM THIS PE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY _____ WEEKS PREGNANT WITH _____ FETUS(ES). HER EXPECTED DELIVERY DATE IS _____.

I HAVE OBTAINED A SIGNED MEDICAL ASSISTANCE APPLICATION FROM THE APPLICANT AND HAVE FORWARDED IT TO THE RSM OR DFCS OFFICE. ☐ YES

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

QP DIRECT PHONE NUMBER _____ SIGNATURE OF QUALIFIED PROVIDER PERSONNEL _____

QUALIFIED PROVIDER NAME AND ADDRESS _____ QUALIFIED PROVIDER ID _____

REIMBURSEMENT FOR MEDICAL ASSISTANCE SERVICES THROUGH THE
 PRESUMPTIVE ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL OR
 DELIVERY SERVICES

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.
 632 (1/28/2019)

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

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

[illegible]

SPECIAL NOTE TO APPLICANTS:

If you have not heard from your county Division of Family and Children Services about your application for Medical Assistance in fifteen (15) days, please contact that office. You must be approved by the county office to have your baby's delivery paid for by Medical Assistance or for Medical Assistance to pay the hospital if you have to be admitted for any reason.

INSTRUCTIONS TO APPLICANTS:

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 the DFCS Call Center or report at www.gateway.ga.gov. If you lose this certification and/or change your address, contact DXC 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 beneficiary 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 APPLICANT for Fair Hearings:

Your eligibility under this special program stops when the RSM/DFCS office makes the decision for your continuing eligibility. When you applied for PE Pregnant Women, you also applied for ongoing and/or retroactive Medical Assistance. When a decision is made on your Medical Assistance eligibility, you will receive a written explanation regarding your continuing eligibility. If you disagree with the decision on your continuing eligibility, you may request a hearing on that decision. Because presumptive eligibility is a temporary Medical Assistance, you are not entitled to a hearing when your presumptive coverage stops.

FAMILY PLANNING SERVICES:

If you want to plan the number of pregnancies, prevent a pregnancy or get a pregnancy test, contact your doctor, or local Department of Public Health Department family planning information and services. They will be glad to explain various methods of family planning and help you in selecting a method that is best for you.

Family Planning services are available in the P4HB program.

WIC SERVICES

If you are expecting a baby or already have small children, **WIC** can help you eat better. The Women, Infants and Children program gives food to low-income pregnant women, new mothers and small children. Ask your local Department of Public Health how to qualify for WIC or call 1-800-228-9173.

-If you are going to have a baby, get healthy food, nutrition information and a medical checkup right away. The local Department of Public Health and WIC can help you.

-After the baby is born, stay healthy and give your baby healthy food. Breastfeeding is best for most babies.

-WIC can help you get milk, cheese, eggs, juice, cereal, peanut butter and baby formula.

NOTICE TO APPLICANT:

When you applied for PE Pregnant Women Medical Assistance, you also applied for ongoing and/or retroactive Medical Assistance. The 94a application will be sent to the Division of Family and Children Services (DFCS) office or the Right from the Start Medical Assistance (RSM) Group. DFCS or RSM will make the decision for your full Medical Assistance benefits and notify you by mail.

This PE Medical Assistance coverage is limited to ambulatory prenatal care and does not provide coverage for inpatient hospital and delivery services. You must be approved for full Medical Assistance benefits in order for the costs of inpatient hospital and delivery services to be covered by the Medical Assistance program.

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

Single Streamlined Medical Assistance Application Form 94a

This 94a form and its attachments **is used to apply for ongoing and/or retroactive Medical Assistance**. The form 94 is no longer used, it has been replaced with the Single Streamlined Medical Assistance application form 94a.

This 94a form is to be included in the PE Pregnant Women Packet that Qualified Providers/Qualified Hospitals will give to either RSM or DFCS. Do **NOT** mail this form or anything to Albany which is the address located on the last page of the form 94a.

This information is also needed to complete the revised PE Pregnant Women Medical Assistance Application form 632 so adding this information to the form 94a is information already known to QP/QH.

If the applicant states she has unpaid medical bill(s) for any of the retroactive months, Section 2, page 2, **Question 12** should be marked as Yes.

94a and the attachments are available in both English and Spanish.



Application for Health Coverage & Help Paying Costs

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](https://www.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.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**.

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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. 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.) <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></td> <td>☐ Chinese</td> <td>☐ Korean</td> <td>☐ Native Hawaiian</td> <td>☐ Other Pacific Islander</td> </tr> <tr> <td></td> <td></td> <td></td> <td></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 _____																		



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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 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.

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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></td> <td>☐ Chinese</td> <td>☐ Korean</td> <td>☐ Native Hawaiian</td> <td>☐ Other Pacific Islander</td> </tr> <tr> <td></td> <td></td> <td></td> <td></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 _____
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	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander																			
				☐ Other _____																			

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

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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? _____ | ☐ 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? _____ | | | |

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 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.

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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 0938-1191. 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: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



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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)
-----------	-------------------

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.



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ATTACHMENT A



GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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? (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

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 36B(c)(2)(C)(ii) 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)



EMPLOYER COVERAGE TOOL



GEORGIA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF FAMILY AND COMMUNITY SERVICES



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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 60 percent of such costs (Section 36B(c)(2)(C)(ii) 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 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 B (9/17)

ATTACHMENT C



GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.

This person is called an "authorized representative." If you ever need to change your authorized representative, contact Division of Family and Children Services (DFCS) at 1-877-423-4746. If you're a legally appointed representative for someone on this application, submit proof with the application.

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

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

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

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



NEED HELP WITH YOUR APPLICATION? Visit 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 C (9/17)



DEPARTAMENTO DE SERVICIOS HUMANOS DE GEORGIA
División de Servicios para Familias y Niños



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Solicitud para Cobertura de Salud y Ayuda Pagando el Costo

Formulario aprobado
OMB Num. 0938-1191

COSAS PARA SABER



Use esta solicitud para ver cuáles opciones de cobertura usted califica

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



¿Quién puede usar esta Solicitud?

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



Solicite más rápido en línea

Solicite más rápido en línea gateway.ga.gov.



Qué necesita para solicitar

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



¿Por qué pedimos esta

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



¿Qué pasa después?

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



Consiga ayuda para hacer esta solicitud

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



¿Necesita ayuda con su solicitud? Visite gateway.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

Form 94a (Rev. 9/17) - Spanish

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

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

1. Primer nombre, segundo nombre, Apellido, Sufijo		2. Parentesco con usted USTED MISMO	
3. Fecha de nacimiento (MM/DD/AAAA):		4. Sexo ☐ Masculino ☐ Femenino	
5. Número de Seguro Social (SSN) _____			
Necesitamos esto si quiere cobertura de salud y tiene un Número de Seguro Social. Proveer su SSN puede ayudar aunque no quiera cobertura de salud ya que puede ayudar a acelerar el proceso de solicitud. Usamos los números de Seguro Social para verificar los ingresos y otra información para ver quién es elegible para ayuda con el costo de cobertura de salud. Si alguien quiere ayuda para obtener un SSN, llame al 1-800-772-1213 o visite socialsecurity.gov. Los usuarios de TTY deben llamar al 1-800-255-0135.			
6. ¿Planea presentar una declaración de impuesto federal el PRÓXIMO AÑO? (Aunque no presente una declaración de impuestos, usted puede solicitar para seguro de salud.) ☐ SI. Si sí, por favor, conteste las preguntas a-c. ☐ NO. Si no, salte a la pregunta c. a. ¿Va a declarar conjunto con su cónyuge? ☐ Sí ☐ No Si sí, nombre del cónyuge: _____ b. ¿Va a reclamar algún dependiente en su declaración de impuestos? ☐ Sí ☐ No Si sí, haga una lista del (los) dependiente(s): _____ c. ¿Será usted reclamado(a) como un(a) dependiente en la declaración de impuestos de otra persona? ☐ Sí ☐ No Si sí, por favor mencione el nombre del declarante de impuestos: _____ ¿Cuál es su parentesco con el declarante de impuestos? _____			
7. ¿Está embarazada? ☐ Sí ☐ No Si sí, ¿cuál es la fecha esperada de alumbramiento / / ; y cuántos bebés está esperando? _____			
8. ¿Necesita cobertura de salud? (Aunque tenga seguro, puede haber un programa con mejor cobertura o un costo más bajo.) ☐ SI. Si sí, conteste todas las preguntas abajo. ☐ NO. Si no, salte a las preguntas sobre ingresos en la página 3. Deje el resto de esta página en blanco			
9. ¿Tiene una condición física, mental o de salud emocional que le cause limitaciones en actividades (como bañarse, vestirse, actividades diarias, etc) o vive en un centro médico o un hogar ancianos? ☐ Sí ☐ No			
10. ¿Es usted un(a) ciudadano(a) de los Estados Unidos o nacional de los Estados Unidos? ☐ Sí ☐ No			
11. Si usted no es ciudadano(a) o nacional de los Estados Unidos, ¿es un inmigrante calificado? ☐ Sí. Llene la información de su tipo de documento y número de ID abajo. a. Tipo de documento de inmigración: _____ b. Número de ID de documento: _____ c. ¿Ha vivido usted en los Estados Unidos desde el 1995? ☐ Sí ☐ No d. ¿Es usted o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? ☐ Sí ☐ No			
12. ¿Usted quiere ayuda para pagar facturas médicas de los últimos tres meses? ☐ Sí ☐ No			
13. ¿Vive usted con al menos un menor de 19 años y usted es el cuidador(a) principal de este menor? ☐ Sí ☐ No			
14. ¿Es usted un estudiante a tiempo completo? ☐ Sí ☐ No 15. ¿Estuvo usted en cuidado tutelar a la edad de 18 años o mayor? ☐ Sí ☐ No			
16. Si es hispano/latino (OPCIONAL—marque todas las que aplican.) ☐ Mexicano ☐ Mexicanoamericano ☐ Chicano ☐ Puertorriqueño ☐ Cubano ☐ Otro _____			
17. Raza (OPCIONAL—marque todas las que aplican.) ☐ Blanco ☐ Indígena estadounidense o de Alaska ☐ Filipino ☐ Vietnamita ☐ Negro o afroamericano ☐ De la India ☐ Japonés ☐ Otro asiático ☐ Chino ☐ Coreano ☐ Indígena de Hawái			

¿Necesita ayuda con su solicitud? Visite gateway.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

Form 94a (Rev. 9/17) - Spanish

Página 2 de 8

PASO 2: PERSONA 1 (Continúe con usted mismo(a))

Trabajo actual e Información de ingresos

☐ **Empleado**

Si está empleado actualmente, díganos sobre sus ingresos. Empiece con la pregunta 18.

☐ **No empleado**

Salte a la pregunta 28.

☐ **Trabajo por cuenta propia**

Salte a la pregunta 27.

TRABAJO ACTUAL 1:

18. Nombre y dirección del empleador	19. N° de teléfono del empleador () -
20. Sueldos/propinas (antes de impuestos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual \$	
21. Promedio de horas trabajadas cada SEMANA	

TRABAJO ACTUAL 2: (Si tiene más trabajos y necesita más espacio, adjunte otra hoja de papel.)

22. Nombre y dirección del empleador	23. N° de teléfono del empleador () -
24. Sueldos/propinas (antes de impuestos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual \$	
25. Promedio de horas trabajadas cada SEMANA	

26. El año pasado ☐ cambio de trabajo? ☐ dejó de trabajar? ☐ empezó a trabajar menos horas? ☐ empezó a trabajar más horas? ☐ ninguno

27. Si trabaja por cuenta propia, conteste las siguientes preguntas:

a. tipo de trabajo

b. ¿Cuánto ingresos netos (ganancias una vez se hayan pagado los gastos del negocio) recibirá de su trabajo por cuenta propia este mes?
\$

28. **OTRO INGRESO:** Marque todas las que apliquen y dé la cantidad y cada cuánto la recibe.

NOTA: Usted no necesita decirnos sobre los ingresos de manutención infantil, pagos de veterano o Ingresos del Seguro Suplementario.

☐ Ninguno		☐ Cantidad neta de pesca u cultivos	\$	¿Frecuencia?
☐ Desempleo	\$	¿Con qué		
☐ Pensiones	\$	¿Con qué		
☐ Seguro Social	\$	¿Con qué		
☐ Cuentas de retiro	\$	¿Con qué		
☐ Pensión alimenticia	\$	¿Con qué		
		☐ Rental/regalis netas	\$	¿Frecuencia?
		Otros ingresos	\$	¿Frecuencia?
		Tipo		

29. **DEDUCCIONES** Marque todas las que aplican y dé la cantidad y cada cuánto la paga.

Si paga por ciertas cosas que pueden ser deducidas en la declaración de impuestos federales y nos deja saber, su costo de cobertura de salud pudiera ser un poco menos.

NOTA: No debe incluir los costos netos que ya declaró en su respuesta de trabajo por cuenta propia (pregunta 27b).

☐ pensión alimenticia	\$	¿Cada cuánto?	☐ Otras deducciones	\$	¿Cada cuánto?
☐ Intereses del préstamos estudiantil	\$	¿Cada cuánto?	Tipo:		

? ¿Necesita ayuda con su solicitud? Visite gateway.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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Página 3 de 8

30. **INGRESO ANUAL:** Complete sólo si sus ingresos cambian cada mes. Sino espera cambios en sus ingresos mensuales, salte a la próxima persona.

Su total de ingresos este año \$	El total de sus ingresos el próximo año (si piensa que será diferente) \$
--	---

GRACIAS! Es todo lo que necesitamos saber de usted.

PASO 2: PERSONA 2

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

1. Primer nombre, segundo nombre, Apellido, Sufijo		2. Parentesco con usted
3. Fecha de nacimiento (MM/DD/AAAA):	4. Sexo ☐ Masculino ☐ Femenino	
5. Número de Seguro Social (SSN) _____ Necesitamos esto si quiere cobertura de salud y tiene un Número de Seguro Social		
6. ¿Vive con usted la PERSONA # 2? ☐ Sí ☐ No Sino, escriba la dirección: _____		
7. ¿La PERSONA # 2 planea presentar una declaración de impuestos el PRÓXIMO AÑO? (Aunque no presente una declaración de impuestos, usted puede solicitar para seguro de salud) ☐ Sí. Si sí, por favor, conteste las preguntas a-c. ☐ NO. Si no, salte a la pregunta c. a. ¿La PERSONA # 2 presentará una declaración de impuestos con un cónyuge? ☐ Sí ☐ No Si sí, nombre del cónyuge: _____ b. ¿La PERSONA # 2 va a reclamar algún dependiente en su declaración de impuestos? ☐ Sí ☐ No Si sí, haga una lista del (los) dependiente(s): _____ c. ¿Será la PERSONA # 2 reclamada como un(a) dependiente en la declaración de impuestos de otra persona? ☐ Sí ☐ No Si sí, por favor mencione el nombre del declarante de impuestos: _____ ¿Cuál es el parentesco de la PERSONA # 2 con el declarante de impuestos? _____		
8. ¿Está embarazada la PERSONA # 2? ☐ Sí ☐ No a. Si sí, ¿cuál es la fecha esperada de alumbramiento /___/ ; y cuantos bebés está esperando? _____		
9. ¿Necesita cobertura de salud la PERSONA # 2? (Aunque tenga seguro, puede haber un programa con mejor cobertura o un costo más bajo.) ☐ Sí. Si sí, conteste todas las preguntas abajo. ☐ NO. Si no, salte a las preguntas sobre ingresos en la página 5. Deje el resto de esta página en blanco.		
10. ¿Tiene la PERSONA # 2 una condición física, mental o de salud emocional que le cause limitaciones en actividades (como bañarse, vestirse, actividades diarias, etc) o vive en un centro médico o un hogar de ancianos? ☐ Sí ☐ No		
11. ¿Es la PERSONA # 2 un(a) ciudadano(a) de los Estados Unidos o nacional de los Estados Unidos? ☐ Sí ☐ No		
12. Si la PERSONA # 2 no es ciudadano(a) o nacional de los Estados Unidos, ¿es un inmigrante calificado? ☐ Sí. Uene la información de su tipo de documento y número de ID abajo. a. Tipo de documento de inmigración _____ b. Número de ID de documento _____ c. ¿Ha vivido la PERSONA # 2 en los Estados Unidos desde el 1996? ☐ Sí ☐ No d. ¿Es la PERSONA # 2 o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? ☐ Sí ☐ No		

¿Necesita ayuda con su solicitud? Visite gateway.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.
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13. ¿La PERSONA # 2 quiere ayuda para pagar facturas médicas de los últimos tres meses? ☐ Sí ☐ No	14. ¿Vive la PERSONA # 2 con al menos un menor menor de 19 años y usted es el cuidador(a) principal de este menor? ☐ Sí ☐ No	15. ¿Estuvo la PERSONA # 2 en cuidado tutelar a la edad de 18 o mayor? ☐ Sí ☐ No
--	---	---

Por favor, conteste las siguientes preguntas si la PERSONA # 2 es menor de 19 años.

16. ¿Tuvo la PERSONA # 2 seguro de salud y lo perdió en los últimos dos meses? ☐ Sí ☐ No
a. Si sí, fecha en que terminó: _____ b. Razón por la cual terminó el seguro: _____

17. ¿Es la PERSONA # 2 un estudiante de tiempo completo? ☐ Sí ☐ No

18. Si es hispano/latino (OPCIONAL—marque todas las que aplican.)
☐ Mexicano ☐ Mexicanoamericano ☐ Chicano ☐ Puertorriqueño ☐ Cubano ☐ Otro _____

19. Raza (OPCIONAL—marque todas las que aplican.)

☐ Blanco	☐ Indígena estadounidense o de Alaska	☐ Filipino	☐ Vietnamita
☐ Negro o afroamericano	☐ De la India	☐ Japonés	☐ Otro asiático
	☐ Chino	☐ Coreano	☐ Indígena de Hawái

Ahora, díganos sobre cualquier tipo de ingresos de la PERSONA # 2 en la parte de atrás.



¿Necesita ayuda con su solicitud? Visite gateway.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en español, llame al **1-877-423-4746**. Si necesita ayuda en algún idioma que no sea inglés, llame al **1-877-423-4746** y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al **1-800-255-0135**.

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PASO 2: PERSONA 2

Trabajo actual e Información de ingresos

- ☐ **Empleado**
Si está empleado actualmente, díganos sobre sus ingresos. Empezar con la pregunta 20.
- ☐ **No empleado**
Salte a la pregunta 30.
- ☐ **Trabajo por cuenta propia**
Salte a la pregunta 29.

TRABAJO ACTUAL 1:

20. Nombre y dirección del empleador	21. N° de teléfono del empleador () -
22. Sueldos/propinas (antes de impuestos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual \$	
23. Promedio de horas trabajadas cada SEMANA	

TRABAJO ACTUAL 2: (Si tiene más trabajos y necesita más espacio, adjunte otra hoja de papel.)

24. Nombre y dirección del empleador	25. N° de teléfono del empleador () -
26. Sueldos/propinas (antes de impuestos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual \$	
27. Promedio de horas trabajadas cada SEMANA	

28. El año pasado, ☐ ¿cambio de trabajo? ☐ ¿dejó de trabajar? ☐ ¿empezó a trabajar menos horas? ☐ ¿empezó a trabajar más horas? ☐ Ninguno

29. Si trabaja por cuenta propia, conteste las siguientes preguntas:

- a. tipo de trabajo
- b. ¿Cuánto ingresos netos (ganancias una vez se hayan pagado los gastos del negocio) recibirá de su trabajo por cuenta propia este mes?
\$

30. **OTRO INGRESO:** Marque todas las que apliquen y dé la cantidad y cada cuánto la recibe.

NOTA: Usted no necesita decirnos sobre los ingresos de manutención infantil, pagos de veterano o Ingresos del Seguro Suplementario.

☐ Ninguno	☐ Cantidad neta de pesca u cultivos	\$	¿Frecuencia?
☐ Desempleo	☐ Rental/regalis netas	\$	¿Frecuencia
☐ Pensiones	Otros ingresos	\$	¿Frecuencia
☐ Seguro Social	Tipo		
☐ Cuentas de retiro			
☐ Pensión alimenticia			

31. **DEDUCCIONES** Marque todas las que aplican y dé la cantidad y cada cuánto la paga.

Si la PERSONA # 2 paga por ciertas cosas que pueden ser deducidas en la declaración de impuestos federales y nos deja saber, su costo de cobertura de salud pudiera ser un poco menos.

NOTA: No debe incluir los costos netos que ya declaró en su respuesta de trabajo por cuenta propia (pregunta 29b)

☐ pensión alimenticia	\$	¿Cada cuánto?	☐ Otras deducciones	\$	¿Cada cuánto?
☐ Intereses del préstamos estudiantil	\$	¿Cada cuánto?	Tipo		

32. **INGRESO ANUAL:** Complete solo si los ingresos de la PERSONA # 2 cambian cada mes.

Si no espera cambios en ingresos mensuales de la PERSONA # 2, agregue otra persona o salte a la próxima sección.

Total de ingresos este año para la PERSONA # 2 \$	El total de ingresos el próximo año para la PERSONA # 2 (si piensa que será diferente) \$
---	---

¡GRACIAS! Es todo lo que necesitamos saber de la PERSONA # 2.

Si tiene más de dos personas que incluir, haga una copia del paso 2: Persona # 2 (páginas 4 y 5) y complete.

 **¿Necesita ayuda con su solicitud?** Visite gateway.ga.gov o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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PASO 3 Familiares de indios americanos o nativos de Alaska (AI/AN, por sus siglas en inglés)

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

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

PASO 4 La cobertura de salud de su familia

Conteste estas preguntas para cualquiera que necesite cobertura de salud.

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

☐ **SI.** Si sí, verifique el tipo de cobertura y escriba el nombre de la persona al lado del tipo de cobertura que tienen.

☐ **NO.**

- ☐ Medical Assistance _____
☐ Medicare _____
☐ TRICARE (No marque si tiene cuidado directo o Line of Duty)
☐ Programas de cuidado de salud de Veteranos _____
☐ Peace Corps _____

- ☐ Seguro del empleador _____
☐ Nombre del seguro de salud: _____
 Número de póliza: _____
 ¿Es esta una cobertura de COBRA? ☐ Sí ☐ No
 ¿Es éste un plan de salud de jubilación? ☐ Sí ☐ No
☐ Otro
 Nombre del seguro de salud: _____
 Número de póliza: _____
 ¿Es éste un plan con beneficios limitados (como una póliza escolar de accidente)? ☐ Sí ☐ No

2. ¿A alguien listado en esta solicitud le han ofrecido una cobertura de salud de un trabajo? Marque **SÍ** aunque la cobertura sea del trabajo de otra persona como un padre (madre) o cónyuge.

- ☐ **SI.** Si sí, necesitará completar e incluir el anejo A.
☐ **NO.** Si no, continúe al paso 5.

PRA Cláusula de Divulgación

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

? ¿Necesita ayuda con su solicitud? Visite gateway.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en español, llame al **1-877-423-4746**. Si necesita ayuda en algún idioma que no sea inglés, llame al **1-877-423-4746** y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al **1-800-255-0135**.

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PASO 6 Envíe la solicitud completa.

Envíe su solicitud firmada a la dirección abajo:

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

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



¿Necesita ayuda con su solicitud? Visite Compass.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en español, llame al **1-877-423-4746**. Si necesita ayuda en algún idioma que no sea inglés, llame al **1-877-423-4746** y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al **1-800-255-0135**.

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ANEXO A



DEPARTAMENTO DE SERVICIOS HUMANOS DE GEORGIA
División de Servicios para Familias y Niños



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Cobertura de salud de los trabajos

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

Cuéntenos sobre el trabajo que ofrece la cobertura.

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

Información sobre el EMPLEADO

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

Información sobre el EMPLEADOR

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

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

☐ Sí (Continúe)

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

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

Nombre: _____ Nombre: _____ Nombre: _____

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

Cuéntenos sobre el plan de salud ofrecido por este empleador.

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

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

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



Form 94a Appendix A (9/17) - Spanish

HERRAMIENTA DE COBERTURA DEL



DEPARTMENT OF COMMUNITY HEALTH
Division of Health Policy and Practice



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

EMPLEADOR

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

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



Información sobre el EMPLEADO

El empleado tiene que llenar esta sección.

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



Información sobre el EMPLEADOR

Pídale al empleador esta información.

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

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

☐ Sí (Continúe)

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

☐ No (PARE y devuelva este formulario al empleado)

Cuéntenos sobre el plan de salud ofrecido por este empleador.

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

☐ Sí. ¿A quién? ☐ Cónyuge ☐ Dependiente(s)

☐ No

(Vaya a la pregunta 14)

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

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

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

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

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

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

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

☐ El empleador no ofrecerá cobertura de salud

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

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

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

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

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

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



Form 94a Appendix A (9/17) - Spanish

ANEXO B



DEPARTAMENTO DE SERVICIOS HUMANOS DE GEORGIA
División de Servicios para Familias y Niños



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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

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

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

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

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

	AI/AN PERSONA 1	AI/AN PERSONA 2
1. Nombre (Nombre de pila, Nombre del medio, Apellido)	Nombre de pila Nombre del medio Apellido	Nombre de pila Nombre del medio Apellido
2. ¿Miembro de una tribu reconocida por el gobierno federal?	☐ Sí Si la respuesta es sí, nombre de la tribu _____ ☐ No	☐ Sí Si la respuesta es sí, nombre de la tribu _____ ☐ No
3. ¿Esta persona alguna vez ha obtenido un servicio de parte del Servicio de Salud para Indios, de un programa de salud tribal, o de un programa de salud para indios urbanos, o a través de una derivación proveniente de uno de estos programas?	☐ Sí ☐ No Si la respuesta es no, ¿Esta persona es elegible para obtener servicios de parte del Servicio de Salud para Indios, de un programa de salud tribal, o de un programa de salud para indios urbanos, o a través de una derivación proveniente de uno de estos programas? Sí No	☐ Sí ☐ No Si la respuesta es no, ¿Esta persona es elegible para obtener servicios de parte del Servicio de Salud para Indios, de un programa de salud tribal, o de un programa de salud para indios urbanos, o a través de una derivación proveniente de uno de estos programas? Sí No
4. Algunos tipos de dinero recibido no pueden ser contados para el Medicaid ni para el Programa de Seguro de Salud de Niños (CHIP, por sus siglas en inglés). Liste cualquier ingreso (cantidad y frecuencia) reportado en su solicitud que incluya dinero de las siguientes fuentes: • Pagos per cápita de una tribu que vienen de recursos naturales, uso de derechos, arrendamientos, o regalías • Pagos por recursos naturales, agricultura, ganadería, pesca, arrendamientos, o regalías de tierra designada como tierra indígena en fideicomiso por el Departamento del Interior (incluyendo reservaciones y ex-reservaciones) • Dinero de la venta de cosas que tienen un significado cultural	\$ _____ ¿Con qué frecuencia? _____	\$ _____ ¿Con qué frecuencia? _____



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

Form 94a Appendix B (9/17) - Spanish

ANEXO C



DEPARTAMENTO DE SERVICIOS HUMANOS DE GEORGIA
División de Servicios para Familias y Niños



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Ayuda para completar esta solicitud

Usted puede escoger a un representante autorizado.

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

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

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

Únicamente para consejeros, navegadores, representantes e intermediarios certificados.

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

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



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

Form 94a Appendix C (9/17) - Spanish

NOTICE OF ACTION Form DMA 634:

634 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 applicant at the time of her PE approval. A copy of this form will be included in the PE packet given to RSM or DFCS.

634 Denial

This form is used to provide notice to the applicant when a PE determination is denied. It is to be given to the applicant at the time she is determined not eligible. A copy of this form will be included in the PE packet given to RSM or DFCS.

COMPLETION OF INDIVIDUAL ITEMS:

Complete the top part of the form showing identifying information:

Check the 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:

- 1) The applicant is not a U.S. citizen or qualified immigrant.
- 2) The applicant is not pregnant per her statement.
- 3) The applicant's net taxable income is above 220% of the federal poverty level limit.
- 4) The applicant is not a GA resident.
- 5) Unable to determine, applicant refuses to verbally give tax status information.

Enter whichever reason is correct.

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

The person completing the Presumptive Eligibility determination will sign the form.



NOTICE OF ACTION

Presumptive Eligibility Pregnant Women Medical Assistance

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

☐ **PRESUMPTIVE ELIGIBILITY APPROVED:** _____
Medical Assistance ID Number

Your application for Presumptive Eligibility (PE) Pregnant Women Medical Assistance is approved.

When you applied for PE Pregnant Women Medical Assistance, you also applied for ongoing/retroactive Medical Assistance. Your Medical Assistance application will be sent to the Division of Family and Children Services (DFCS) Office or the Right from the Start Medical (RSM) Assistance Group for a final determination of eligibility. DFCS or RSM will make the decision for your full Medical Assistance application and notify you by mail.

This PE Medical Assistance coverage is limited to ambulatory prenatal care and does not provide coverage for inpatient hospital and delivery services. You must be approved for full Medical Assistance benefits in order for the costs of inpatient hospital and delivery services to be covered by the Medical Assistance program.

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

Signature of Qualified Provider _____ Qualified Provider Address _____
Title _____ Phone Number _____ Qualified Provider ID Number _____
634 (Approval) Revised 1/15/19



AVISO DE ACCIÓN

Presuntiva Elegibilidad Asistencia Médica Para Mujeres Embarazadas

Nombre _____ Fecha _____
Dirección _____
Ciudad _____ Estado GA Código Postal _____

☐ **ELEGIBILIDAD PRESUNTIVA APROBADA:** _____
Número de Identificación de Asistencia Médica

Se aprueba su solicitud de Asistencia Médica de Mujeres Embarazadas de Elegibilidad Presuntiva (PE).

Cuando solicitó asistencia médica para mujeres embarazadas con (PE), también solicitó Asistencia Médica continua/retroactiva. Su solicitud de Asistencia Médica se enviará a la Oficina de la División de Servicios para Familias y Niños (DFCS) o al Grupo de Right From The Start Medical Assistance (RSM) para una determinación final de elegibilidad. DFCS o RSM tomarán la decisión de su solicitud de asistencia médica completa y le notificarán por correo.

La cobertura de Asistencia médica estará limitada a la atención prenatal ambulatoria y no brinda cobertura para servicios hospitalarios y de parto. Se debe aprobar los beneficios de Asistencia médica completa para que los costos de los servicios hospitalarios y de parto sean cubiertos por el programa de Asistencia médica.

Su cobertura de (PE) Asistencia Médica finaliza cuando la oficina de DFCS o el grupo de RSM realiza una determinación final de elegibilidad, o antes del último día del siguiente mes de su solicitud de Asistencia Médica.

Firma del Proveedor Calificado

Dirección del Proveedor Calificado

Título

Número de Telefono

Número de Identificación del
Proveedor Calificado

634 (Approval) SP Revised 1/15/19



NOTICE OF ACTION

Presumptive Eligibility Pregnant Women Medical Assistance

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

☐ **PRESUMPTIVE ELIGIBILITY DENIED**

Your application for Presumptive Eligibility (PE) Pregnant Women Medical Assistance is denied.

The reason for denial is: Choose Item

When you applied for PE Pregnant Women Medical Assistance, you may also have applied for ongoing/retroactive Medical Assistance. Your Medical Assistance application will be sent to the Division of Family and Children Services (DFCS) Office or the Right from the Start Medical (RSM) Assistance Group for a final determination of eligibility. DFCS or RSM may determine you are potentially eligible for another type of Medical Assistance and will notify you. If you are not eligible for Medical Assistance, your Medical Assistance 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 _____

634 (Denial) Revised 1/15/19



AVISO DE ACCIÓN

Presuntiva Elegibilidad Asistencia Médica Para Mujeres Embarazadas

Nombre _____ Fecha _____
Dirección _____
Ciudad _____ Estado GA Código Postal _____

☐ **ELEGIBILIDAD PRESUNTIVA NEGADA**

Su solicitud para la Asistencia Médica de Mujeres Embarazadas de Presuntiva Elegibilidad (PE) es denegado.

El motivo de la negación es: Choose Item

Cuando solicitó PE Asistencia Médica para Mujeres Embarazadas, también solicitó Asistencia Médica continua/retroactiva. Su solicitud de Asistencia Médica se enviará a la Oficina de la División de Servicios para Familias y Niños (DFCS) o al Grupo de Right from the Start Medical (RSM) para una determinación final de elegibilidad. DFCS o RSM pueden determinar que usted es potencialmente elegible para otro tipo de Asistencia Médica y le notificarán. Si no es elegible para Asistencia Médica, su solicitud de Asistencia Médica será remitida al Mercado Federal Facilitado (FFM) para su consideración. La FFM le notificará directamente.

Puede encontrar información adicional sobre FFM o solicitar directamente la cobertura de atención médica en www.healthcare.gov, o puede llamar al FFM en cualquier momento al 1-800-318-2596, TTY 1-855-889-4325.

Firma del Proveedor Calificado

Dirección del Proveedor Calificado

Título

Número de Telefono

Número de Identificación del
Proveedor Calificado

634 (Denial) SP Revised 1/15/19

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 divulgamos 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

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

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

PURPOSE

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

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

PREPARATION

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

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

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

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

If no TPL are reported, do not complete a form DMA 285. A new form should be completed when TPL are added or if there is a change in employer related group coverage. Mark "Change" box and show the new information in the appropriate section. If a previously TPL is no longer valid, i.e., is dropped or cancelled, use one of the retained copies of the form and check the "cancellation" block, record the effective date of the cancellation on the line labeled "Policy Termination Date" and send to HMS.

EXAMPLE OF FORM DMA 285 COMPLETED:

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

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

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

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25); 42 CFR 433.135-139). 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 Adult Parent?
☐ YES ☒ NO

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

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

ATTACH A COPY OF INSURANCE
CARD/POLICY AND A COPY OF SNT

Do any of the persons listed above have a chronic medical condition? ☐ YES ☒ NO If yes, Name _____ Condition _____

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

Types of Coverage (circle those which apply)

01 - HOSPITAL INPT. 15 - LTC/NH
 07 - DRUG/STND 16 - HMO/DRUG
 08 - MAJOR MED. 17 - MED. SUPP A
 09 - DENTAL 18 - MED. SUPP B
 10 - VISION 22 - HMO/STND
 OTHER _____

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

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

Signed Applicant's Signature Date 01/01/xx
 Member or Authorized Person

Signed Signature Date 01/01/xx
 Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY 01/01/xx

Case Worker Name: Qualified Provider Worker Phone No: Direct Phone County _____

DMA-285-REV. (01/00)

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

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

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

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25); 42 CFR 433.135-139). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

Do you have a private, group or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) ☐ 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
--	--

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

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

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

 (Insurance Company Name) (Telephone Number)

 (Address) (City) (State) (Zip)

 (Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

 (Policy Effective Date) (Policy Termination Date)

 (Employer Name) (Telephone Number)

 (Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)
 01 – HOSPITAL INPT. 15 – LTC/NH
 07 – DRUG/STND 16 – HMO/DRUG
 08 – MAJOR MED. 17 – MED. SUPP A
 09 – DENTAL 18 – MED. SUPP B
 10 – VISION 22 – HMO/STND
 OTHER _____

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

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

Signed _____ Date _____ Signed _____ Date _____
 Member or Authorized Person Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY _____

Case Worker Name: _____ Phone No: _____ County _____

Quick Guide on PE Pregnant Women Medical Assistance

This document is for informational purposes, only. For applicants, who apply and are approved for PE with QP/QH, it explains to them about PE Pregnant Women Medical Assistance and what to expect if their application is approved for the program.

To assist the applicant in keeping abreast of the status of her Medical Assistance application, this document contains an entry for the telephone number of the RSM or DFCS office. QP/QH should supply this number and give the temporary Medical Assistance Certification (approvals) to the applicant, along with other forms she receives, as part of the application process.



Quick Guide on Presumptive Eligibility Pregnant Women Medical Assistance

Presumptive Eligibility (PE) Pregnant Women Medical Assistance is temporary Medical Assistance. PE Pregnant Women Medical Assistance provides ambulatory prenatal care and pharmacy services. It does not cover inpatient hospital stay or delivery services.

If you applied for ongoing and/or retroactive Medical Assistance, your application is being sent to the Right from the Start Medical (RSM) Assistance Group or the Division of Family and Children Services (DFCS) office for a final eligibility determination.

A RSM or DFCS Medical Assistance Eligibility Specialist may contact you for additional information. You will receive a letter in the mail letting you know whether or not your application is approved for ongoing and/or retroactive Medical Assistance. If approved, Medical Assistance will cover you as long as you are pregnant and for 60 days after you deliver your baby. There are other types of Medical Assistance that may cover you after this point, you can ask RSM or DFCS.

You must report all household changes within 10 days. You can report the changes to the DFCS Call Center at 1-877-423-4746 or online at www.gateway.ga.gov.

Soon after you are eligible for full Medical Assistance, you will be enrolled in one of the four Care Management Organizations (CMO): Amerigroup, CareSource, PeachState or WellCare. If you would like to change your CMO, you will have 90 days to do so. You can change your CMO, by calling Georgia families at 1-888-423-6765, online at www.georgia-families.com, by mail or fax.

Following approval and beginning in your 8th month of pregnancy, you will receive a form from the DFCS office asking if you are still pregnant or have had your baby. You must complete the form and return it.

Before you leave the hospital, you should get a temporary Medical Assistance card to cover your baby until the plastic one comes in the mail. After you have your baby, contact the DFCS Call Center at 1-877-423-4746 to report the baby's name and birth date. You can fax your newborn's information to 1-888-740-9355 or report the birth online at www.gateway.ga.gov. Once you report this information, your baby will receive Newborn Medical Assistance for his/her first year. There are no renewals during this first year under Deemed Newborn Medical Assistance.

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

Medical Assistance covers prenatal care, delivery and most medical services and items; there are no co-pays for pregnant members. If you have questions about what else Medical Assistance covers, ask your doctor or call 1-866-211-0950.

Revised 1/15/19



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

Guía rápida sobre presunta elegibilidad Asistencia médica para mujeres embarazadas

Elegibilidad presunta (PE) La asistencia médica para mujeres embarazadas es asistencia médica temporal. PE La asistencia médica de mujeres embarazadas brinda atención ambulatoria prenatal y servicios de farmacia. No es así Cubrir los servicios de estadia hospitalaria para pacientes internados o servicios de parto.

Si solicitó asistencia médica continua y / o retroactiva, su solicitud se envía a la derecha del Grupo de Asistencia Start Medical (RSM) o la División de Servicios para Familias y Niños (DFCS) oficina para una determinación final de elegibilidad

Un especialista en elegibilidad para asistencia médica de RSM o DFCS puede comunicarse con usted para obtener información adicional. Tú recibirá una carta por correo que le informa si su solicitud está aprobada o no y / o Asistencia médica retroactiva. Si se aprueba, la Asistencia Médica lo cubrirá mientras usted esté embarazada y durante 60 días después de dar a luz a su bebé. Hay otros tipos de asistencia médica que pueden Te cubro después de este punto, puedes preguntarle a RSM o DFCS.

Debe informar todos los cambios en el hogar dentro de los 10 días. Puede informar los cambios al Centro de llamadas de DFCS al 1-877-423-4746 o en línea en www.gateway.ga.gov.

Poco después de ser elegible para recibir Asistencia Médica completa, se le inscribirá en una de las cuatro Cuidados Organizaciones de gestión (CMO): Amerigroup, CareSource, PeachState o WellCare. Si desea para cambiar su CMO, tendrá 90 días para hacerlo. Puede cambiar su CMO, llamando a Georgia familias al 1-888-423-6765, en línea en www.georgia-families.com, por correo o fax.

Tras la aprobación ya partir de su 8º mes de embarazo, recibirá un formulario de la DFCS oficina preguntando si todavía está embarazada o si tuvo su bebé. Debe completar el formulario y devolverlo.

Antes de salir del hospital, debe obtener una tarjeta de Asistencia Médica temporal para cubrir a su bebé hasta el plástico viene por correo. Después de tener a su bebé, comuníquese con el Centro de llamadas de DFCS al 1-877-423-4746 para informar el nombre y la fecha de nacimiento del bebé. Puede enviar por fax la información de su recién nacido al 1-888-740-9355 o informar el nacimiento en línea en www.gateway.ga.gov. Una vez que informe esta información, su bebé recibirá Asistencia médica para recién nacidos para su primer año. No hay renovaciones durante este primer año bajo Asistencia Médica Recién Nacida Considerada.

Si necesita una tarjeta de asistencia médica de reemplazo, llame al Centro de contacto para miembros al 1-866-211-0950.

Asistencia médica cubre la atención prenatal, el parto y la mayoría de los servicios y artículos médicos; no hay copagos para miembros embarazadas Si tiene preguntas sobre qué más cubre Medical Assistance, consulte a su médico o llama al 1-866-211-0950.

Revisado el 1/15/19

Presumptive Eligibility Manual Updates

This form should be used when QH/QP do not have internet access, errors occur preventing QH/QP to enter eligibility in GAMMIS, P4HB case needs to be terminated and/or demographic information needs to be corrected.

Complete the form only for the section(s) that need to be updated. Email the completed form along with the PE application (632) only to DCH at pecorrections@dch.ga.gov. Subject line: PE Manual Updates (make email High Priority).

Updates will be completed the same business day if received by 5:00 pm or on the next business day if received after 5:00 pm or on the weekend.



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



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

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Revised 1/15/19

APPENDIX G - GAMMIS

Sign on to GAMMIS:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

Sign in to the Georgia Medicaid

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

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

Sign in to Georgia Medicaid [Help](#)

Username:

Password:

Sign In

Georgia Medicaid
Forgot your password?

User Name

Password

Get Password

Privacy

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

Georgia Medicaid Home

Public Health Welcome to Georgia Medicaid

Applications

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

Sign Out

Privacy

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

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

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

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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 Address
 Medicaid Provider ID City
 Name Zip

If you have more than one choice choose your office.

(2 rows returned)

National Provider ID	Medicaid Provider ID	id	Provider Type	Name	Address	City	State	Zip	Zip + 4
		26G	Public Health A						100
		29N	Public Health A						165

Select row above to switch to the desired provider.

Messages:


**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](#)

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

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

User Information - Provider 000457729N
?

Messages
Top

Category	Subject	Sent Date	Effective Date	End Date	Remove
PROVIDER ALERT	Suspended Claim Attachments	12/01/2010	12/01/2010	12/31/2010	☐
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 Medical Assistance.

The screenshot shows the Georgia Department of Community Health Web Portal. The header includes the Georgia Department of Community Health logo, the text "GEORGIA WEB PORTAL", and the Georgia Health Partnership logo. A blue banner at the top says "Welcome Public Health" and includes a "Search" button. Below the banner, a message indicates the session will expire in 19 minutes. A navigation menu lists various services: Home, Contact Information, Member Information, Provider Information, Provider Enrollment, Nurse Aide, EDI, Pharmacy, Account, Training, Claims, Eligibility, Presumptive Activations, Health Check, and Prior Authorization. The "Eligibility Request" section is active, showing a "User Information - Provider 000457" dropdown menu with options for Newborn Activations, Pregnant Women Activations, and Women's Health Activations. A note states: "Note: If a member is enrolled in a managed care plan on the date of admission, the plan is responsible for the entire stay as long as Medicaid eligibility is maintained. If the member is enrolled in a fee for service program on the date of admission, then the fee for service program is responsible for the entire hospital stay as long as Medicaid eligibility is maintained." Below the note is the "Eligibility Verification Request" form with fields for Member ID, Last Name, First Name, Gender, Birth Date, SSN, and From/Thru Date of Service. Search and clear buttons are at the bottom right.

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

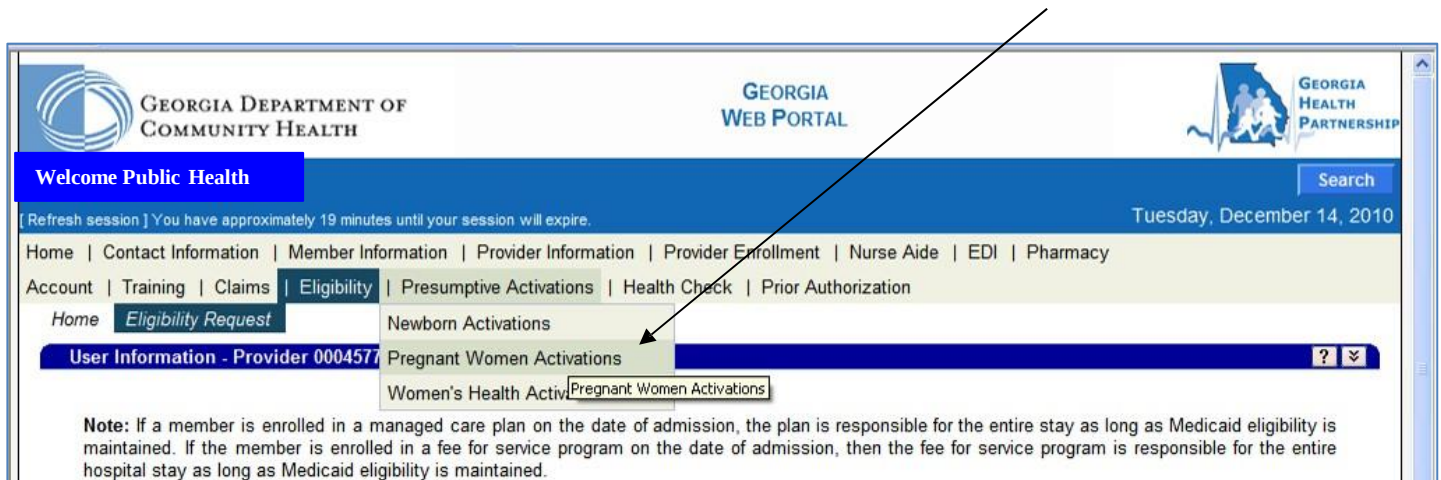
The screenshot shows the "Eligibility Verification Request" form filled out with the following information: Member ID: 111222333444, Birth Date: 12/4/19XX, Last Name: SMITH, First Name: L., Gender: F, From/Thru Date of Service: 09/30/20XX to 10/24/20XX. Below the form is the "Member ID Information" section, which displays the member's details: 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. An arrow points to the Member ID field with the text "Her original Medicaid Number will appear here." Below the member information is the "Eligibility Spans" section, which shows a table with the following data:

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

An arrow points to the "Inactive" status in the table.

If she has never had Medical Assistance this screen will not appear.

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



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

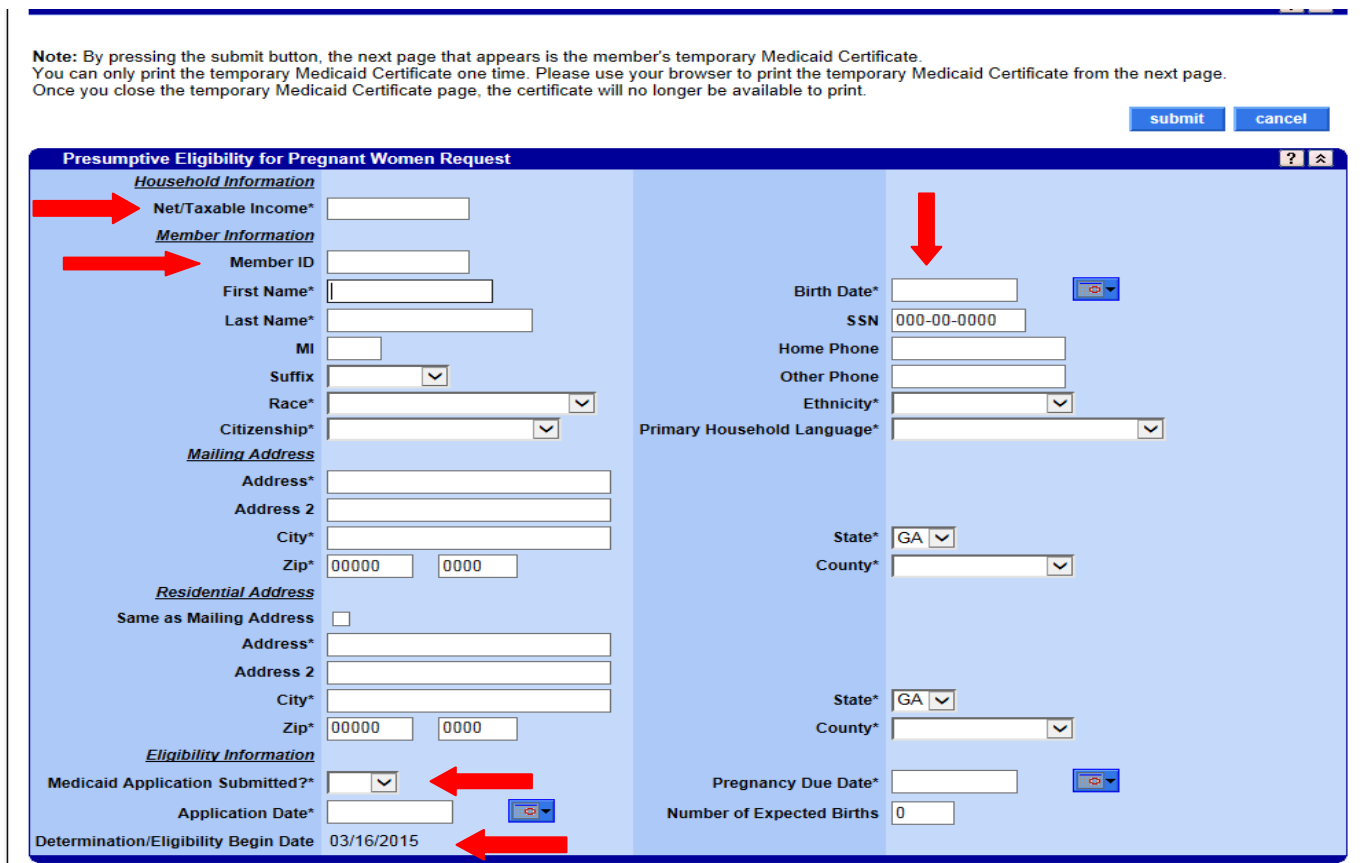
Home **Eligibility Request** Newborn Activations

User Information - Provider 0004577 Pregnant Women Activations ?

Women's Health Activations Pregnant Women Activations

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.

The PE Screen will appear:



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

submit cancel

Presumptive Eligibility for Pregnant Women Request ?

Household Information

Net/Taxable Income* []

Member Information

Member ID []

First Name* []

Last Name* []

MI []

Suffix []

Race* []

Citizenship* []

Mailing Address

Address* []

Address 2 []

City* []

Zip* [] []

Residential Address

Same as Mailing Address []

Address* []

Address 2 []

City* []

Zip* [] []

Eligibility Information

Medicaid Application Submitted?* []

Application Date* []

Determination/Eligibility Begin Date 03/16/2015

Pregnancy Information

Birth Date* []

SSN []

Home Phone []

Other Phone []

Ethnicity* []

Primary Household Language* []

State* GA []

County* []

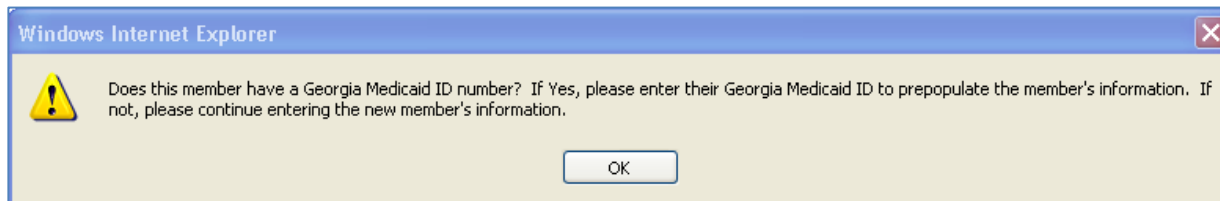
Pregnancy Due Date* []

Number of Expected Births 0

Enter the applicant's original ID number to auto-populate the fields on this Presumptive Eligibility Pregnant Women Revised July 1, 2019

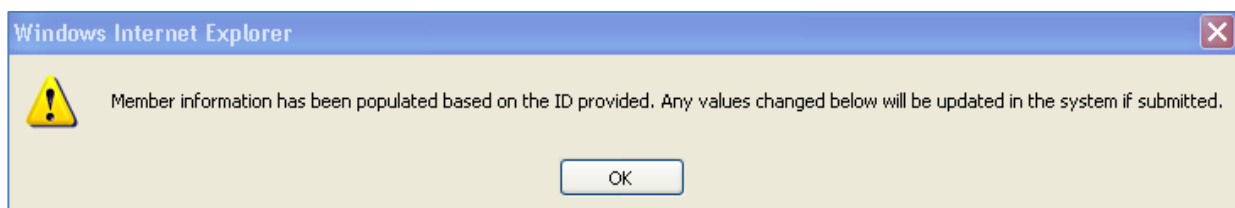
panel.

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 Changes/Corrections procedure after you enter the PE in the Web.

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



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

<u>Eligibility Information</u>	
Medicaid Application Submitted?*	v
Application Date*	v
Pregnancy Due Date*	v
Determination/Eligibility Begin Date	03/16/2015
Number of Expected Births	0

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 next page. Once you close the temporary Medicaid Certificate page, the certificate will no longer be available to print.

Presumptive Eligibility for Pregnant Women Request

Member Info

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 111222333444. 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 Pregnant Women Request ?

[Member Info](#)

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



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

GEORGIA
WEB PORTAL



GEORGIA
HEALTH
PARTNERSHIP

Welcome, Search

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

Temporary Member Identification Card

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

Thank you for your participation in the Medicaid/PeachCare for 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 003858

Eligibility Verification Request ?

From/Thru
Date of Service

Member ID Information ?

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

Eligibility Spans ?

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

Appendix I – Income

*Look for *MAGI* or *FM* in the ‘Eligibility’ column to determine if income is excluded (E) or included (I).

INCOME	TREATMENT OF INCOME
--------	---------------------

2499 – TREATMENT OF INCOME IN MEDICAL ASSISTANCE

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

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

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

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

INCOME		TREATMENT OF INCOME	
CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ADOPTION ASSISTANCE	Unearned – Payment received for the adoption of certain children.	E (MAGI and Non MAGI)	E
	IV-E Exclude as income.	E (MAGI and Non MAGI)	E
	IV-B Exclude as income.		
ADVANCE	Unearned – Money for future expenses that does not represent a gain to the AU.	E (MAGI and Non MAGI)	E
	Earned – A prepayment of wages or salaries.	I (MAGI and Non MAGI)	I
AGENT ORANGE PAYMENTS	Unearned – A payment made to a Vietnam Veteran who was exposed to Agent Orange defoliant. The payment is made to the surviving spouse and children.	E (MAGI and Non MAGI)	I
ALASKA NATIVE CLAIM	Unearned – Payments made under Alaska Native Claims Settlement Act.	E (MAGI and Non MAGI)	I
	Alaska Permanent Fund Dividend- payment from Alaska's mineral income fund.	I (MAGI and Non MAGI)	I
ALIMONY/ SPOUSAL SUPPORT	Unearned – A court-ordered payment from an estranged spouse or former spouse to the other spouse for support under the terms of a court order or settlement agreement following a divorce. Payments may be in one lump sum, or in a series of monthly payments. Alimony is also termed "spousal support" or "maintenance".	I (MAGI and Non MAGI)	I
AMERICORPS	Income from Americorps Network of programs which encompasses: Americorps USA Americorps VISTA Americorps NCCC Are handled as specified below:		

VOLUME II/MA, MT 49 – 12/17	SECTION 2499-2
-----------------------------	----------------

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	Living Allowance Stipend – Earned Income	E (Non MAGI) I (MAGI)	E
	On-the Job Training – Earned Income	E (Non MAGI) I (MAGI)	E
ANNUITY	Unearned – Recurring payment received from an investment. Refer to Section 2339 , Trust Property, Annuities.	I (MAGI and Non MAGI)	I
ASSISTANCE BASED ON NEED (ABON)	Unearned – assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a state or local government.	E (MAGI and Non MAGI)	E
BLACK LUNG BENEFITS	Unearned – benefits paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act. Phone number for United Mine Workers is 1-800-654-9763.	I (Non MAGI) E (MAGI)	I
BLOOD, sale of	Earned – Money received from the sale of blood including blood products.	I (MAGI and Non MAGI)	I
BOARDER INCOME	Earned – Direct payments for food and related shelter expenses, less the cost of doing business.	I (MAGI and Non MAGI)	I
BONUS	Earned – Wages paid in addition to the usual or expected wages. Refer to Wages in this chart.	I (MAGI and Non MAGI)	I
CAPITAL GAINS	Earned or Unearned – profits from the sale of capital goods or equipment. Capital assets are resources such as stock, securities, real estate and equipment that are typically held as an investment for a period of time. A capital gain is realized when the item(s) sold have appreciated in value from the original purchase price.	I (MAGI and Non MAGI)	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CENSUS INCOME	Earned- All wages paid by the Census Bureau for temporary employment related to Census activities.	E (MAGI and Non MAGI)	E
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATION NOT STATE/ FEDERALLY FUNDED	Unearned – Charitable donation paid to the AU or BG.	E (MAGI and Non MAGI)	E
CHARITABLE DONATION FROM FEDERALLY OR STATE FUNDED ORGANIZATION	Unearned – Charitable donation paid to the AU or BG from organizations receiving state or federal funds. For example: Salvation Army, United Way, Catholic Charities, and Lutheran Social Service Agencies.	I (MAGI and Non MAGI)	I
CHILD CARE ATTENDANT (wages earned by)	Earned – income received for providing child care services. Consider the income as follows: Self-employment if the attendant provides child care services in his/her home As wages if the attendant provides services in the home of the child.	I (MAGI and Non MAGI)	I
CHILD CARE PAYMENTS	Unearned – Payments made under Title IV of the Social Security Act to a child care provider on behalf of the AU. These payments include Transitional Child Care, and At Risk block grant child care payments made under P.L. 101-508, Section 5801 of the Social Security Act.	E (MAGI and Non MAGI)	E
CHILD NUTRITION PAYMENTS	Unearned – The value of meals provided to a child in day care through the Child Nutrition Amendment of 1978. * If the payment is for a child of the attendant, budget the entire amount as	*I (MAGI and Non MAGI)	I

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS (cont'd)	the payment. Notices providing the amount of the annuity and the adjusted amount of the annuity are reliable evidence of the gross amount. If an individual's records are unavailable, complete Form 990, Benefits Verification, and direct the inquiry to the following address: Office of Personnel Management Retirement and Insurance Coverage 1900 E. Street, NW Washington, D.C. 20415		
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. Refer to Wages in this chart. If the payment is recurring, include it when determining representative pay. If not, do not include the pay. Refer to Section 2653 , Prospective Budgeting.	I (MAGI and Non MAGI)	I
CONTRACTED EMPLOYMENT INCOME	Earned – Income received from jobs in which there is a contract or payment agreement. Determine the gross monthly amount by dividing the total amount during the life of the contract by the number of months specified in the contract.	I	I
CONTRIBUTION, GIFT, PRIZE, AWARD	Unearned – Money given to the AU as a gift from individuals or organizations. *ABD: If the contribution is in the form of food, clothing or shelter, value the contribution as ISM, including third party vendor payments resulting in food, clothing, or shelter to the A/R. EXCEPTION: Never include ISM as income for an A/R in LA-D.	*I (ABD and Non MAGI) E (MAGI)	I
DEATH BENEFITS	Unearned – a benefit received as the result of another's death, such as the following:	*I (MAGI and Non MAGI)	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	• Cash or in-kind gifts given by relatives, friends, or a community group to "help out" with expenses related to the death • Inheritances in cash or in kind • Lump sum death benefits from SSA • Proceeds of life insurance policies received due to the death of the insured • RR Retirement burial benefits • VA burial benefits NOTE: Recurring survivor benefits such as those received under Title II (RSDI), private pension programs, etc., are not death benefits. * Death benefits provided to an individual are income to the individual to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the individual. Last illness and burial expenses include related hospital and medical expenses; funeral, burial plot, and interment expenses; and other related expenses. Verify all last illness and burial expenses. If verification (e.g., bills, receipts, contact with provider, etc.) cannot be obtained, accept the individual's signed allegation. If an expense has been incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No follow-up is required if the assumption is applied. Use judgment to determine whether an expense is reasonably related to the last illness and burial. It is expected that related expenses may include such items as new clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc.		

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
A/R	(DFM) to whom the income is diverted in the eligibility and CCSP/ICWP cost share budgets, if the spouse /DFM is a Medical Assistance A/R. Refer to Section 2554, Diversion of Income. Include as unearned income to the A/R from whom the income is diverted in the eligibility budget. Allow as a patient liability/cost share budget deduction. Verify from the NH, CCSP or A/R's case record. EXCEPTION: Diverted income is included in PL when a community spouse enters LA-D. Refer to Spousal Impoverishment budgeting.	I	E
DIVIDENDS	Unearned – A share of profits received by a policy holder or shareholder. NOTE: Any dividends left to accrue are a resource separate from the resource that is earning dividends. - For ABD, any dividends earned on countable resources are not counted as income. - For non-FBR COAs, dividends earned on excluded life insurance policies are excluded as income. *For Family, dividends earned on life insurance policies are a countable resource. NOTE: Non-participating life insurance policies do not earn/pay dividends. Use Form 106 or other acceptable documents to verify dividends.	*E	*E
DOMESTIC VOLUNTEER SERVICES PAYMTS	Unearned – Payments to volunteers under the federal government program	E	I
EARNED INCOME TAX CREDIT (EITC)	Unearned – A special tax credit which reduces the federal tax liability of	E	E

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ENERGY ASSISTANCE PAYMENTS	Unearned – Payment or allowance received under federal, state, and local law for the purpose of assisting the AU with the cost of heating and cooling its home. These include HUD and FMHA Utility reimbursements.	E	E
FARM ALLOTMENTS	Unearned – Payments from government sponsored programs such as Agricultural Stabilization and Conservation Services which are a gain or a benefit to the AU.	I	I
FARMING	Earned – Income received from agricultural labor. Refer to Section 2415, Self-Employment .	I	I
FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS	Unearned – food and shelter assistance provided in cash or in kind in emergency disaster situations. Exclude if the assistance is designated as home energy assistance or support and maintenance assistance. Otherwise, contact the State Medical Assistance Unit for further instructions.	E	E
FEDERAL PROGRAMS, MISCELLANEOUS	• 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 NOTE: Contact the State Medical Assistance Unit if there is a payment that is not on this list and it is questionable as to whether it should be excluded or counted.	E	E

INCOME**TREATMENT OF INCOME**

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EMERGENCY/ CRISIS INTERVENTION SERVICES	This payment is used to help pay for the cost of emergent needs incurred by the grandparents when the children come to live with them. *For ABD, do not deem GRG income of the A/R's parent or spouse to the A/R.		
GRANDPARENTS RAISING GRANDCHILD-REN SUBSIDY PAYMENT	UNEARNED-TANF Subsidy in the amount of \$50.00 per child per month used assist low income (fixed income) grandparents (60+) to cover additional expenses associated with rearing their grandchildren. *For ABD, do not deem GRG income of the A/R's parent or spouse to the A/R.	ABD-I* FM-E	I
GRANDPARENT PAYEE	* The Grandparent payee's income is not counted in the TANF budget. The children's TANF income is not counted in the Grandparent Payee's ABD budget.	*	*
HEALTH REIMBURSEMENT ACCOUNT	An account through an employer which may only be used to reimburse individuals for certain medical services. * Count any income received in excess of the incurred expense(s) as unearned income.	*E	*E
HOME PRODUCE	Unearned-home produce used for personal consumption and not offered for sale.	E	E
HOUSING AND DEVELOPMENT (HUD) RENTAL REFUND	Unearned – Payment received by the AU for rent. Payments are often distributed by the Georgia Residential Financial Authority (GRFA). Payments can be made directly to the AU, by a two-party check or directly to the landlord on behalf of the AU.	E	E
HOUSING AND URBAN DEVELOPMENT (HUD) OR FARMERS HOME ADMINISTRATION	Unearned – Utility reimbursement provided by HUD and FMHA to AUs who receive housing assistance and are responsible for paying their utilities separately from their rent.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
(FMHA) UTILITY REIMBURSEMENT	Payments can be paid directly to the AU, by a two-party check or directly to the utility company on behalf of the AU.		
INCOME BASED ON NEED (IBON)	Unearned – Assistance provided under a program that considers other income as a factor in determining eligibility and is funded wholly or partially by the federal government or a non-governmental agency for the purpose of meeting basic needs (TANF, SSI, VA Pension, etc.). Continued next page.	See specific type of IBON	See specific type of IBON
INCOME BASED ON NEED (IBON) (cont.)	NOTE FOR ABD: Do not allow the \$20 general exclusion to IBON. Do not deem IBON received by the A/R's spouse or parent to the A/R.		
INCOME TAX REFUND	*Refer to the Chapter 2300, Resources, to determine how to count income tax refunds. For how to count in PL/CS, refer to Section 2552, PL/CS Deductions .	*	*
INDIAN LAND GRANTS	Unearned – Federal distributions to members of Indian Tribes.	E	E
INDIAN GAMBLING ACT PAYMENTS	Tribally managed gaming revenues * If the funds have NOT been held in trust by the Secretary of the Interior, count as unearned income. If held in trust by the Sec. of Interior, exclude.	*	*
INHERITANCE	Unearned– cash, a right or non-cash item(s) received as a result of someone's death. Exclude expenses for the last illness & burial of the deceased if paid by the inheritor. NOTE: Until an item or right has a value or is accessible, it is neither income nor a resource.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
IN-KIND ITEMS RECEIVED IN LIEU OF WAGES	Earned – Wages may include the value of food, clothing, shelter or other items provided in lieu of cash wages.	I (ABD) E (MAGI and Non MAGI)	E
IN-KIND SUPPORT AND MAINTENANCE	Unearned – Any gain or benefit that is not in the form of money payable directly to the AU such as meals, clothing, produce or housing. * Refer to Section 2430 , Living Arrangements and In-Kind Support and Maintenance.	*I (ABD) E (MAGI and Non MAGI)	E
INSURANCE BENEFITS DUE TO LOSS OF INCOME	Unearned – benefits paid from an insurance policy due to loss of income. * Refer to Section 2230 , Third Party Resources, for information on benefits paid to cover medical expenses.	*I	*I
INTEREST	Unearned – Income paid from bank account deposits, life insurance or other financial instruments/investments. FAMILY: Annualize for prospectively budgeted AUs to determine a monthly amount. *Exclude amounts of \$1.00 or less per month. ABD: The following types of interest earned on countable resources are excluded as income in the eligibility and PL/CS budgets: • Interest earned on all countable financial instruments, such as checking/savings accounts, CDs, etc. • Interest earned on countable Patient Fund Accounts. *Exception: Interest portion of payment made on contracts are counted as income. *NOTE: If total interest earned on excluded resources is \$20/month or	Family-*I ABD-E*	E*

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	less, exclude in the Medical Assistance eligibility and AMN spenddown budgets. If total interest earned on excluded resources exceeds \$20/month, include all the interest in the eligibility and spenddown budgets. See exceptions below.		
INTEREST Burial Contracts	Exclude interest earned on the excluded portion of a burial contract for FBR A/Rs.	E	E
Burial Funds	Exclude all interest earned on a burial contract for non-FBR A/Rs if left to accrue.	E	E
	Exclude interest earned on the excluded portion of funds set aside for burial for FBR A/Rs.	E	E
	Exclude interest earned on the first \$5000 of funds set aside for burial for non-FBR A/Rs if left to accrue.	E	E
INTEREST Dividends	Exclude interest earned on the dividend accumulations from excluded life insurance policies for ABD non-FBR A/Rs.	E	E
	For Family, include interest earned on life insurance policies, stocks and mutual funds.	I	I
	For ABD, exclude as income dividends/interest earned on countable resources such as stocks and mutual funds.	E	E
IRREGULAR/ INFREQUENT INCOME	Earned and Unearned – Income that is received too infrequently or irregularly to be anticipated, regardless of the amount. Refer to Section 2504 for definition of irregular or infrequent income. Treat such income as the following: - Earned income of \$30 or more received over a three month period - Earned income of less than \$30 received over a three month period	I E-ABD I-Family E-ABD	I I I

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	Unearned income of less than \$60 received over a three-month period Unearned income of \$60 or more received over a three-month period	I-Family I	 I
JAPANESE – AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS (PL 100-383)	Unearned – Restitution payments made by the U.S. Government to Japanese-Americans and Aleutians or their survivors as a consequence of their evacuation, relocation and internment during World War II.	E	E
JURY DUTY	Earned – Compensation received for serving on a jury.	I	I
LOANS FROM OTHERS (PERSONAL OR BUSINESS): A/R is making payments	Unearned – Money received that the borrower has an obligation to repay. Requires a prepayment agreement (written or oral).	E	E
LOANS TO OTHERS (Payment made to A/R)	Unearned - Money loaned to persons outside the AU where a repayment agreement exists. Payments received are considered income. * ABD, refer to Section 2313 .	I *	I*
LOTTERY WINNINGS	Unearned – A sum of money received as a result of purchasing a winning ticket in a game of chance. * Refer to the appropriate sections on Lump Sum budgeting for Family or ABD Medical Assistance.	*	*
LUMP SUM Children in Placement	Unearned – A sum of money that is received at one time. This may be an accumulated amount or a one-time occurrence. * Count as income in month of receipt. Any remainder is counted as a resource beginning the month after receipt (refer to Resources Chart 2399.1, Lump Sums). For all AFDC related categories of Medical Assistance, a lump sum is treated as income in the month received and as a resource in any amounts thereafter.	*	*

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

INCOME**TREATMENT OF INCOME**

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
Army	USAFAC Director, Retired Operations Indianapolis, IN 46246 ATTN: Management Support Office		
Marine Corps	Parallel FO: D24 Marine Corps Finance Center 1500 E. 95th Street Kansas City, MO 64197		
Navy	Parallel FO: D24 Retired Pay Department Code 305, Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199		
MILITARY RETIREMENT LUMP SUM	Unearned – Consider as unearned income in the month of receipt. Treat as a resource the month following the month of receipt.	I	I
MONTGOMERY GI BILL PAYMENTS	UNEARNED-VA payments for individuals enrolled in Active Duty or the Selected Reserve of the Army, Navy, Air Force, Marine Corps, Coast Guard, or Air National Guard for up to 36 months of education assistance. NOTE: Any portion of funds that come from the individual's earnings is counted as income.	E	E
NATIONAL EMERGENCY GRANT (DISASTER RELIEF EMPLOYMENT)	UNEARNED-Grants funded by FEMA, used to provide disaster relief employment on projects that provide food, clothing, shelter and other humanitarian assistance for disaster victims.	E	E
NATIONAL FLOOD INSURANCE PAYMENTS	UNEARNED- Payments made for flood mitigation activities under the National Flood Insurance Act of 1968.	E	E
NOISE ABATEMENT PAYMENTS	Unearned – Non-recurring payment designated for noise abatement work on a dwelling.	E	E
OLDER AMERICANS ACT/ SENIOR COMMUNITY SERVICE	Earned – Title V income paid for community service employment to individuals 55 or over. This includes Green Thumb income. Anything provided under these programs other	ABD - I FM - E	I

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

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

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

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ROOMER	Earned – Direct payments for room only.	I	I
RSDI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly RSDI check by SSA to recover an overpayment of RSDI benefits to the individual *Refer to Repayment of Overpayment of Benefits on Page 2499-21.	ABD – I FM – E*	E
SALE – LEASEBACK	Unearned – the homeowner transfers title of the home to a buyer (e.g., an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. The difference between payments on the installment note and the rental cost provides the former homeowner with cash. Under this arrangement, the buyer is responsible for the payment of real estate taxes, major maintenance, and casualty insurance. Some sale-leaseback arrangements involve the purchase of an annuity. Treat as the conversion of a resource, not as income. Interest earned from an installment note Annuity payments	E I I	E I I
SCHOOL LUNCH PROGRAM	UNEARNED-The cash value of assistance provided to children under the National School Lunch Program, Child Nutrition Act, Special Milk Program, or School Breakfast program.	E	E
SELF EMPLOYMENT	Earned – income from a self-employed enterprise.	I	I

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
SICK PAY (cont'd)	Earned – If paid from employer's payroll. Unearned – Paid by insurance company or a source other than an employer.	I E (MAGI) I (Non MAGI)	
SPECIAL AND DEMONSTRATION VOLUNTEER PROGRAMS	Unearned – Payments to volunteers under a federal government program	E	I
SPENDING ACCOUNT	EARNED-Pre-taxed earnings that are deducted from an employee's gross wages and placed in an account to pay AU expenses such as childcare and medical costs.	I	I
STRIKE BENEFITS	Unearned – Income received by individuals on strike.	I	I
SUPPLEMENTAL SECURITY INCOME (SSI)	Unearned – monthly payments made to aged, blind or disabled individuals from the federal government. SSI is administered by the Social Security Administration. Consider as Income Based on Need (IBON). SSI recipients also receive Medical Assistance. * For ABD, do not deem the ineligible parent or spouse's SSI income to the A/R. However, include SSI in the Couple eligibility budget when one member of the couple is AMN and the other receives SSI. ** Refer to Section 2578, SSI Recipients, for information on including SSI income in nursing home patient liability budgets.	ABD-*I FM – E	**I
SSI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly SSI or RSDI check by SSA to recover an overpayment of SSI benefits to the individual.	ABD – I FM – E	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	Exclude a SSI recoupment from a SSI check, but include a SSI recoupment from an RSDI check, in the patient liability budget. For Family Medical Assistance, refer to Repayment of Overpayment of Benefits through Benefit Reduction in TANF, SSI, RSDI, UCB or others on page 2499-19.		
SUSAN WALKER VS BAYER CORPORATION SETTLEMENT PAYMENTS	A cash settlement as a result of a class action lawsuit. Unearned	E	E
TAX REFUNDS	A refund of taxes paid on food, income or property. It may be considered as earned or unearned.	E	*
Earned	A refund of federal or state taxes paid on income.	E	*
Unearned	A refund of taxes paid on food or property, such as real property or automobiles. Refer to Section 2405, Treatment of Income. * Refer to Section 2552, PL/CS Deductions.	E	*
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments. TANF benefits received from another state are budgeted for the month of receipt only. *For ABD, do not deem TANF income of the A/R's parent or spouse to the A/R.	ABD – I* FM - E	I
TIPS	Earned – Voluntary payments above	I	I

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

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

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	the dependent(s).		
Augmented VA Benefits To NH/CCSP A/Rs	Unearned * Refer to Section 2418 , VA Income for specifics on counting Augmented VA income for LA-D A/Rs. NOTE: Augmented VA benefits are treated differently than augmented RR benefits. The entire amount of an augmented RR check is income to the beneficiary.	ABD-*I FM-E	*I
VA Recoupment	Repayment of VA benefits which are deducted from the VA check.	I Count the gross amount for eligibility determination FM-E	E Count the gross less recoup-ment
VA Lump Sum	Unearned Any portion of a VA lump sum that is not VA Aid and Attendance, is not VA UME reimbursement or is not augmented is counted as unearned income for the month of receipt.	ABD-*I FM-E	*I
VICTIM RESTITUTION	Unearned – Money received by a victim of a crime from a crime victim restitution program, usually a reimbursement for financial losses. The value of the payment does not exceed the value of the loss	E	E
	The value of the payment exceeds the value of the loss.	E	E
VICTIM RESTITUTION (cont'd)	Count the excess value as income in the month of receipt.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	The payment is a set monthly amount based on a court ruling. Count as income in the month of receipt.	I	I
VISTA VOLUNTEER PAYMENT	Earned – Income received by VISTA volunteers under Title I of the Domestic Volunteer Services Act. Included are payments from the Urban Crime Prevention Program	E	E
VOLUNTEER PAYMENT RSVP Foster Grandparent/ VISTA Urban Crime Prevention	Unearned – Title II of Domestic Volunteer Services Act of 1973 Unearned – Payments from Title I. Exclude only if the A/R was receiving FS or AFDC at the time they joined Title I even if there is a break in participation.	E E	I I
WAGES (SALARIES) Children in Placement	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. Reference Section 2835, PROCEDURES , Earnings of an AFDC Child, for exclusion criteria.	I	I
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 A/R in connection with claim. Verify from the employer or from the source of the payment.	ABD-I FM-E	I
WORKFORCE INVESTMENT ACT	Earned – Income received while working as part of a WIA program.	I	I

INCOME**TREATMENT OF INCOME**

WORK STUDY PROGRAM (Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	E	N/A
WORK STUDY PROGRAM (Non-Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	I	N/A
WORK SUPPORT PAYMENTS (WSP)	A time limited cash supplement to a TANF assistance unit that, because of employment, either becomes ineligible for TANF or experiences a reduction in its TANF benefit amount and declines ongoing TANF in order to stop the TANF clock. *For ABD, do not deem WSP income of the A/R's parent or spouse to the A/R.	ABD-I* FM-E	I
YOUTH BUILD PROGRAM PAYMENTS	EARNED- Payments made through the Youth Build Program. *See WIA for treatment of this income.	I*	I*
YOUTH PROJECT PAYMENTS	Unearned – Payments made through projects developed to assist youth in acquiring work skills including the following: • Youth incentive entitlement pilot project • Youth community conservations and improvement projects • Youth employment *See WIA for treatment of this income.	I*	I*

APPENDIX M

MEMOS

MEMO Date	Title
2/20/15	Presumptive Eligibility Medicaid Federal Poverty Levels for 2015
3/4/15	GAMMIS system changes for Presumptive Pregnant Women and Presumptive Women's Health Medicaid
7/9/15	Same Sex Marriage- How do we treat Income and Resources
3/11/16	Presumptive Eligibility Medicaid Federal Poverty Levels for 2016
8/21/14	RSDI Income of Tax Dependents for MAGI based Medicaid and PeachCare for Kids determinations
2/20/17	Presumptive Eligibility Medicaid Federal Poverty Levels for 2017
2/19/18	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2018
9/11/18	Clarification to Declaration of Citizenship/Immigration Status
10/24/18	Dependent Tax Filing Threshold
2/20/19	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2019



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

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March 4, 2015

MEMORANDUM

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

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

RE: GAMMIS system changes for Presumptive Pregnant Women and Presumptive Women's Health Medicaid

The purpose of this Memorandum is to inform Qualified Providers of the system changes within GAMMIS in reference to the begin date of eligibility for persons who are determined presumptively eligible and changes to the panels implemented on 02/26/15.

Presumptive Eligibility (PE) Start Date

Members determined Presumptively Eligible will have an eligibility start date based on the date the Qualified Provider determines the member eligible for Presumptive Eligibility. The member's eligibility will no longer revert to the first day of the month.

Women's Health Medicaid Panel Changes

- Women's Healthcare Request panel has been changed to Women's Health Medicaid Panel
- Determination/Eligibility Begin date field- This field will replace the Eligibility Begin Date field. The date in this field will represent member's effective date of eligibility. The system will default to the current date. The member's eligibility will no longer revert to the first day of the month.
- Net income -The members calculated net income
- Application date- This is the date the member applied for PE services. This date cannot be more than 30 calendar days in the past or future.
- Medicaid Application submitted Y/N- Select Y or N if the member completed a full Medicaid application.

Pregnant Women Panel Changes:

- Determination/Eligibility Begin date field- This field will replace the Eligibility Begin Date field. The date in this field will represent the member's effective date of eligibility. The system will default to the current date. The member's eligibility will no longer revert to the first day of the month. Application Date- This is the date the member applied for PE services. This date cannot be more than 30 calendar days in the past or future.
- Net taxable income -The member's net taxable income.
- Medicaid Application Submitted Y/N- Select Y or N if the member completed a full Medicaid application.
- Presumptive Pregnant Women will now have the aid category of 864. Aid category 865 will no longer be available; however the member will be eligible to receive the same level of coverage and services.

Please distribute to all State office staff, supervisors, and members of the QP team that process the PE Pregnant Women Medicaid and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact Anika Washington, awashington1@dch.ga.gov, Program Consultant at 404-657-7263.

cc: Jonathan Duttweiler, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DFCS Office of Family Independence
Ginger Henry, Interim Medicaid Policy Unit Manager, DFCS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director
Shelia Alexander, PeachCare for Kids® Program Director
Barbara E. Crane, Director, Office of Cancer Screening and Treatment, DPH
Cathy Broom, Program Consultant, DPH
Paula Brown, Project Officer, DPH
Barbara Vance, Myers and Stauffer



July 9, 2015

MEMORANDUM

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

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

RE: Same Sex Marriage - How do we treat Income and Resources?

Question:

If we have a same sex married couple, how do we treat income and resources, both if they indicate they file jointly or indicate they file separately. How do we determine who gets included in a Parent/Caretaker with children budget, if income eligible?

Response:

On June 26, 2015, the Supreme Court, in *United States v. Obergefell ET AL. v. Hodges*, Director, Ohio Department of Health, ET AL. held: "The Fourteenth Amendment requires a State to license a marriage between two people of the same sex and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out of state." In addition "The Court, in this decision, holds same-sex couples may exercise the fundamental right to marry in all States. It follows that the Court also must hold – and it now does hold – that there is no lawful basis for a State to refuse to recognize a lawful same-sex marriage performed in another State on the ground of its same-sex character." Governor Deal states Georgia will abide by the Federal law. As of June 26, 2015 Georgia recognizes same sex marriage for the Medicaid and PeachCare for Kids® programs.

For Medicaid Modified Adjusted Gross Income (MAGI), Non-MAGI and PeachCare for Kids® programs the treatment of income and resources will be the same for same sex married couples and married couples of the opposite sex.

Please note we do not count resources in MAGI.

Ginger Henry
Page 2
July 9, 2015

Please update the Office of Family Independence Medicaid procedures manual to reflect this change throughout. Also, issue a numbered bulletin to expedite the dissemination of this information. If you have any questions or need additional information please contact Karen Y. Houston at 404-657-7270.

cc: Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, Deputy General Counsel
James Knox, Director of Medicaid Legal Services
Wesley Merritt, QC Program Director 2
Randall Solomon, Interim Member Enrollment Director
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2016

DATE: March 11, 2016

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2016. The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2016 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in processing presumptive eligibility effective April 1, 2016.

Group	Parent/Caretaker with Children Under Age 19			Children 6-18		Children 1-5		Children 0-1		Pregnant Women		PCX		P466	
	FPL	Defective	Plus 5%	133%	Plus 5%	100%	Plus 5%	205%	Plus 5%	220%	Plus 5%	247%	Plus 5%	200%	Plus 5%
1	310	50	360	1317	1367	1476	1526	2030	2080	2178	2228	2446	2496	1980	2030
2	457	67	524	1776	1843	1990	2057	2737	2804	2937	3004	3298	3365	2670	2737
3	551	84	635	2235	2319	2504	2588	3444	3528	3696	3780	4150	4234	3360	3444
4	653	102	755	2694	2796	3018	3120	4152	4254	4455	4557	5002	5104	4050	4152
5	752	119	871	3153	3272	3532	3651	4859	4978	5214	5333	5854	5973	4740	4859
6	826	136	962	3611	3747	4046	4182	5566	5702	5973	6109	6707	6843	5430	5566
7	903	154	1057	4072	4226	4561	4715	6276	6430	6735	6889	7561	7715	6122	6276
8	970	171	1141	4533	4704	5078	5249	6987	7158	7498	7669	8418	8589	6816	6987
9	1034	188	1222	4995	5183	5595	5783	7698	7886	8262	8450	9275	9463	7510	7698
10	1113	206	1319	5455	5661	6111	6317	8408	8614	9023	9229	10,130	10,336	8202	8408
11	1194	223	1417	5916	6139	6628	6851	9119	9342	9786	10,009	10,987	11,193	8896	9119
12	1244	240	1484	6378	6618	7145	7385	9830	10,070	10,550	10,790	11,844	12,084	9590	9830

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

Carrie Summers
Page 2
March 11, 2016

Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level. Please use this income limit chart effective April 1, 2016.

Budget	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 Hospital Staff, Supervisors, and members of the QH team that process the PE Pregnant Women Medicaid, PE Parent/Caretaker with Children Medicaid, Children under 19 Medicaid, and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact, Gloria D. Hill, Healthcare Program Consultant 3, at 404-463-0521, cell 470-259-8609 or ghill1@dch.ga.gov.

cc: Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Medical Assistance Group Director
Tara Dickerson, Deputy General Counsel
Randall Solomon, Member Enrollment Director
Wesley Merritt, QC Program Director 2
Sheila Alexander PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



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Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

August 21, 2014

MEMORANDUM

TO: Jonathan Duttweiler, Medicaid Policy Unit Manager
DFCS Office of Family Independence

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

RE: Social Security Retirement, Survivor's, Disability Insurance (RSDI) Income of Tax Dependents for Modified Adjusted Gross Income (MAGI) based Medicaid and PeachCare for Kids® determinations.

BACKGROUND

The Patient Protection and Affordable Care Act of 2010 required the use of new financial methodologies when determining Medicaid eligibility for MAGI classes of assistance. This methodology redefines the financial household by utilizing the tax filing status of an applicant or beneficiary. The household composition rules are applied to classes of assistance that are required to use MAGI methodology to determine household taxable income and eligibility.

PURPOSE

To provide additional clarification on Social Security RSDI received by a tax dependent child for MAGI based budgeting based on the Affordable Care Act (ACA) effective January 1, 2014.

If the tax dependent/child has no other source of income and resides with a parent (biological, step, adopted), the Social Security RSDI income is excluded. RSDI of a tax dependent/child is countable only if the tax dependent/child has OTHER income that meets the IRS tax filing threshold for tax dependents or if the child does not reside with a parent and is not claimed as a tax dependent by his or her parent.

Jonathan Duttweiler
Page 2
August 21, 2014

Note: The filing threshold is applied based on whether the individual should file a tax return. If the individual does not file, the threshold still applies.

The current (2013) IRS tax filing thresholds for tax dependents are:

- \$6100 annually for EARNED income
- \$1000 annually for UNEARNED income

Note: RSDI does NOT count toward the unearned threshold.

Note: The 2014 IRS tax filing thresholds will begin in January 2015.

Please update the Office of Family Independence Medicaid procedures manual to reflect this clarification. Also, issue a numbered bulletin to expedite the dissemination of this information. If you have any questions or need additional information please contact Karen Y. Houston at khouston@dch.ga.gov or 404-657-7270 or Mollie Elder at melder@dch.ga.gov or 404-463-8369.

cc: Jon Anderson, Deputy Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, RSM Project Director
Tara Dickerson, DCH Legal Services, Director
Wesley Merritt, QC Program Director 2
Sheila Alexander, PeachCare for Kids® Program Director
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | 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 Medicaid Federal Poverty Levels for 2017

DATE: February 20, 2017

The purpose of this memorandum is to inform Qualified Providers (QP) 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 the Department of Public Health effective April 1, 2017.

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

Budget Group	5% Deduction	220% PGW
1	N/A	N/A
2	68	2,978
3	86	3,744
4	103	4,510
5	120	5,277
6	138	6,043
7	155	6,809
8	173	7,576
9	190	8,342
10	207	9,108
11	225	9,875
12	242	10,641

For each additional person over Budget Group size 12 add \$763



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Dr. Lara Jacobson
Page 2
February 20, 2017

PE 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 State Office Staff, Supervisors and members of the QP team that process 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
Latoya Osmani, Department of Public Health
Randall Solomon, Member Enrollment Director
Sheila Alexander, PeachCare for Kids® Program Director 2
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | 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



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Dr. Lara Jacobson
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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

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

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OF COMMUNITY HEALTH**

Nathan Deal, Governor

Frank W. Berry, Commissioner

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

MEMORANDUM

TO: Bradly Green, Medicaid Policy Unit Manager
DFCS Office of Family Independence

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

RE: Clarification to Declaration of Citizenship/Immigration Status

DATE: September 11, 2018

On November 30, 2016, the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) issued its final rule for provisions of the Affordable Care Act (ACA). One of the final provisions was proposed at 42 CFR §435.406(a)(3).

42 CFR §435.406(a)(3) states, "a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative, as defined in §435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status".

The language in the final rule was revised to clarify that to make declaration on another person's behalf, the individual must attest to having knowledge of the person's citizenship or immigration status. Examples of individuals who might have knowledge of another person's citizenship or immigration status and can make declaration on another person's behalf include: parent, spouse, friend, an adult family member, friend or acquaintance who can attest to knowing the person's status.

Effective immediately, any individual age 18 or older included in the application does not have to sign the application or a separate declaration of citizenship (Form 216) unless the applicant does not have knowledge of the person's citizenship or immigration status.

Please immediately inform staff of this clarification, update section 2215 of the Office of Family Independence Medicaid Manual, and submit Change Requests for any needed revisions in Georgia Gateway. If you have any questions or need additional information, contact Kunita Snead at 404-463-6234 or Kunita.snead@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
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director 2
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

Frank W. Berry, Commissioner

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October 24, 2018

MEMORANDUM

TO: Bradly Green, Medicaid Policy Unit Manager
DFCS Office of Family Independence

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

RE: Dependent Tax Filing Threshold

This Memorandum will provide notification of the dependent Tax Filing Threshold for 2018. The threshold for not being required to file a tax return is determined yearly by the Internal Revenue Service (IRS), and is \$6350 for earned income for tax year 2017. The threshold for unearned income is \$1050. These amounts listed should be used effective January 1, 2018. Please update Georgia Gateway and the Office of Family Independence Medicaid policy manual to include this change. If you have any questions please contact Kunita Snead at Kunita.Snead@dch.ga.gov or 404-463-623 or Yvonne Greene at ygreene@dch.ga.gov or 404-463-2135.

cc: Blake Fullenwider, Chief, Medical Assistance Plans
Jonathan Duttweiler, Assistant Chief, Member Services and Policy
Ann Carter, Operations Director, DHS Office of Family Independence
Kristen Hernandez, Director, RSM Medical Assistance Group
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director
Stefanie Ashlaw, Director, PeachCare for Kids®
Barbara Vance, Myers and Stauffer



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 2019

DATE: February 20, 2019

The purpose of this memorandum is to inform Qualified Providers (QP) 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 the Department of Public Health effective March 1, 2019.

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	71	3,101
3	89	3,911
4	108	4,721
5	126	5,532
6	145	6,342
7	163	7,152
8	181	7,963
9	200	8,773
10	218	9,583
11	237	10,394
12	255	11,204

For each additional person over Budget Group size 12:
Add \$19 (5% Deduction)
Add \$811 (220% FPL)



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PE 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 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.

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, Director, Right from the Start Medical Assistance Group
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Melanee Payne, Interim Director, Quality Control
Stefanie Ashlaw, Director, PeachCare for Kids®
Latoya Osmani, Department of Public Health
Cathy Broom, Department of Public Health
Paula Brown, Department of Public Health
Karen Salter, Myers and Stauffer

Appendix R -Resources

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

 Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	 CareSource 1-855-202-1058 www.caresource.com
 Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	 WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe

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 (1-888-423-6765) 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
245	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 (DFACS)
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
215	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

280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto – Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary

662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. 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 1-800-766-4456 (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, 2015, 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[®] program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialled 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 1-800-766-4456.

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
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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.	
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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
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpg.org	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	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
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 1-800-766-4456 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) 455-6558 (fax)

Non-Emergency Transportation

Need a Ride?

Georgia Medicaid currently contracts with two Non-Emergency Medical Transportation (NEMT) Brokers to arrange NEMT services for eligible Medicaid 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, Upson, Webster, Wilcox and Worth.

Planning for Healthy Babies® PostCard

**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®

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).



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:



[Refresh session] You have approximately 19 minutes until your session will expire. Wednesday, October 04, 2017

Home | Contact Information | **Member Information** | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD

Home | **Member Notices** | Find a Provider | FAQ for Members | Register for Secure Access

★ GAMMIS Member Notices <- Bookmarkable Link ★ Click here for help and information about bookmarks

User Information 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
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Member Notices (10 rows returned)			
Title	File Type	Size (KB)	Release Date
Understanding Medical Assistance	PDF	1681.1	10/01/2017
Georgia Families Frequently Asked Questions and Answers - Members	PDF	441.5	09/05/2017
105-8 Important Notice	PDF	74.4	01/26/2016
Home and Community Services Booklet 2016	PDF	2446.7	01/21/2016
Home and Community Services Booklet 2014	PDF	487.3	03/21/2014
New Co-payments for Prescriptions for Kids	PDF	98.6	02/21/2012
Form 1415B - Member's Release of Information	PDF	29.6	03/09/2011
Fulfillment Review Submission Package	PDF	32.3	03/09/2011
Home and Community Services Booklet	PDF	6686.7	10/27/2010
Health Check Brochure	PDF	1090.3	10/26/2010

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Web Print

You may print the booklet from the web at the addresses below:

https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/MEMBER%20NOTICES/medical%20assistance%20plans%20booklet%20%20final_e%2020171003130824.pdf

OR

www.dch.ga.gov

Select Medicaid

Select Medicaid Publications from the left column

Under related Files Select “Medical Assistance Plans booklet”



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 ? | 8

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
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ALL FORMS

Forms (57 rows returned)			
Title	Category	Size (KB)	Release Date
DMA-832: 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	CLAMS	31.90	02/03/2011
Medicaid-PeachCare for Kids Provider Information Change Form	ENROLLMENT	36.50	02/18/2011
DMA-292: Request for Forms or Handbooks	ALL FORMS	79.59	03/01/2011



Mail DMA 292 Form

- Mail form DMA 292 to:

DXC Technology
 P. O. box 105209
 Tucker, GA 30085-5209

HP will ship within five (5) business days. Order any quantity you need; each box can contain 400 booklets maximum.

