PART II

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



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE PLANS

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Policy Revisions Record
Part II Policies and Procedures Manual for
PE Women's Health Medical Assistance Eligibility
Program 2021

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
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1/1/21	702	Updated PE Corrections form name to PE Manual Update form	M	
1/1/21	Appendix E	Updated 2021 SSI amounts	M	
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4/1/21	Appendix I	Updated chart with the 2021 FPL limits	M	
4/1/21	Appendix M	Removed duplicate chart for 2020 FPL limits	D	
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4/1/21	Appendix M	Removed Title "Planning for Healthy Baby (P4HB) "Within Three Years of Application Date for a Very Low Birth Weight (VLBW) baby" from table of contents because no Memo in manual associated with this	D	
4/1/21	Appendix R	Updated NEMT information	M	
7/1/21	Footer	Updated revised date	M	
7/1/21	Throughout the manual	Remove WellCare CMO references	D	
7/1/21	Appendix F	Removed GA Families 360 information and replaced with updated GA Families	M	
7/1/21	Appendix F	Removed outdated instructions regarding HIPAA complaints and added updated HIPAA English and Spanish Forms	M	
7/1/21	Appendix M	Added Memo "Planning for Healthy Babies (P4HB) 'Within' Three Years'"	A	
10/1/21	Footer	Updated revised date	M	
10/1/21	Appendix F	Updated "Form Table of Contents" with new form revision dates for recently updated forms DMA 632W, COD, 634W, PST, PE Manual Update form, Quick Guide and WHM Fact Sheet	M	

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10/1/21	502	Added U.S. National and COFA migrants to Citizenship Policy as populations that meet the Citizenship/Qualified alien status.	M	
10/1/21	204	Updated PE WHM Training Dates	M	

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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 during the application processing period and remove barriers to the availability of cancer treatment care critical in positively affecting the health of the woman.

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

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

CHAPTER 200 OVERVIEW OF PRESUMPTIVE ELIGIBILITY

201 Definition and Description of Presumptive Eligibility (PE) Option

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

PE is a determination performed by the Qualified Provider (QP)/ Qualified Hospital (QH) which includes the Department of Public Health (DPH), Federally Qualified Health Centers (FQHC), and Rural Health Centers (RHC). Coverage is available prior to a formal determination of eligibility by the Division of Family and Children Services (DFCS).

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

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

If the applicant is determined eligible for WHM, she will receive a temporary Medical Assistance certificate for her first month of eligibility. If the eligibility continues, she receives the plastic Medical Assistance Member Identification Card for newly approved members. If a member was previously issued a Medical Assistance Member Identification Card, she will not automatically be mailed a new card. Replacement cards are requested by the member via online through GAMMIS or by calling Gainwell Technologies at 1-866-211-0950. This number will remain the same throughout the member's eligibility.

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

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

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

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

These forms, along with a copy of the PE WHM application form 632W and Certificate of Diagnosis will be forwarded to DFCS for a formal determination of Medical Assistance eligibility. Procedures for routing forms daily to DFCS must be emailed to womenshealth@dhs.ga.gov or faxed to 912-377-1134.

The completed PE WHM application packet must be received by DFCS the same day the PE WHM application is taken or within 5 business days from date of application; email the PE WHM packet directly to DFCS at womenshealth@dhs.ga.gov or faxed to 912-377-1134.

202 Summary of Process

The PE process involves the Qualified Provider (QP)/Qualified Hospital (QH), the Department of Community Health (DCH), the Georgia Medical Assistance Management Information System (GAMMIS), and the Department of Family and Children Services (DFCS). The QP/QH determines eligibility for the presumptive period, DFCS determines eligibility for ongoing and retroactive Medicaid, and DCH/GAMMIS issues the Medical Assistance member certification card and provides reimbursement to participating providers for Medical Assistance approved services.

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

After this PE WHM activity is approved, the eligible member is given a temporary Medical Assistance certificate. The QP/QH sends the completed PE WHM application packet to DFCS. Upon receipt of the PE packet, the Medical Assistance application will be entered in Gateway and eligibility will be determined. Retroactive months are available to members who have a confirmed diagnosis three months prior to the application date. Notice is given to the member regarding the eligibility finding, and the results of the determination are forwarded to the DCH/GAMMIS for appropriate processing.

When DCH/GAMMIS receives the eligibility information and an open record is established for the member for payment of claims. When DCH/GAMMIS is notified by DFCS of the results of the Medicaid determination, the record is continued as an active Medical Assistance record if eligible or the PE WHM is closed if ineligible.

Subsequent changes of address and/or loss of their Medical Assistance card should be reported by the member to the Gainwell Technologies Member Contact Center at 1-866-211-0950 or directly to DFCS.

203 Certification Process and Liability

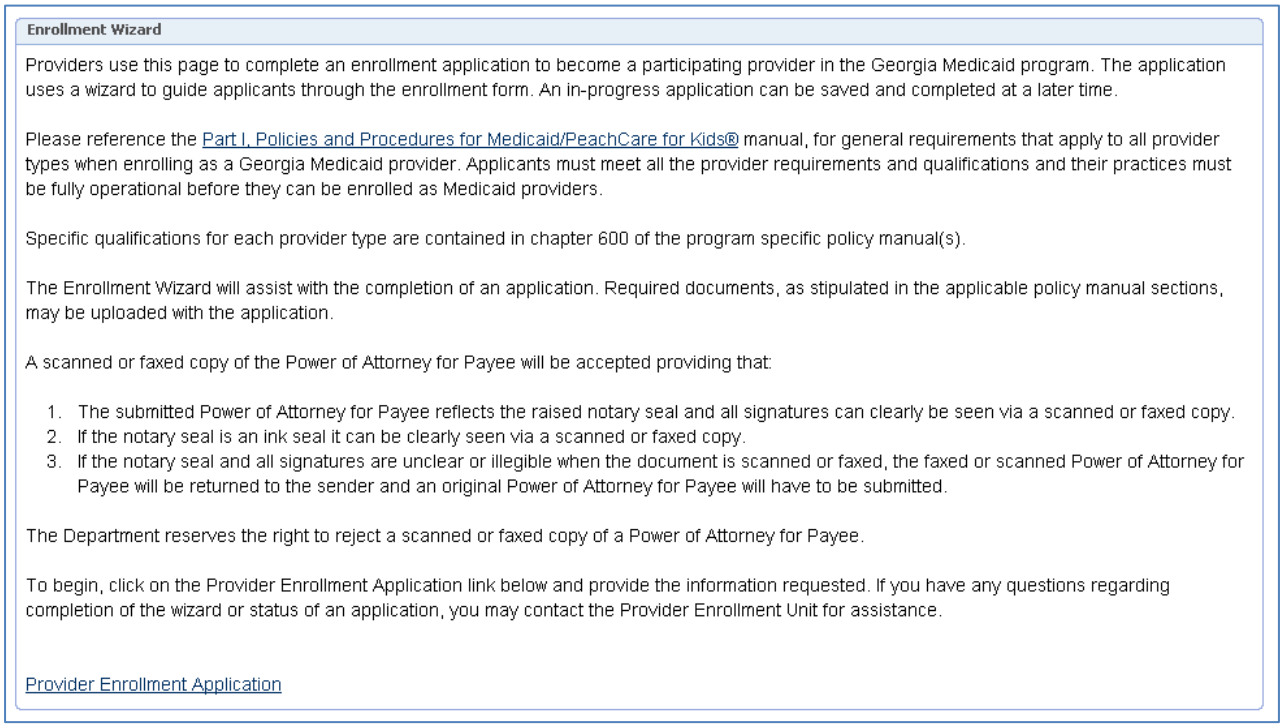
Providers who meet the requirements of participation will be given the opportunity to become a Qualified Provider (QP)/Qualified Hospital (QH). The training requirement is met by attending a presumptive workshop and satisfactorily performing the training exercises.

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

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

Gainwell Technologies Provider Enrollment
P.O. Box 105200
Tucker, GA 30085-5200

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



Enrollment Wizard

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

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

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

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

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

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

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

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

Provider Enrollment Application

204 Responsibilities of a Qualified Provider/Qualified Hospital

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

2022 PE WHM Training Schedule

Due to COVID-19 Pandemic, PE WHM training will be conducted through Microsoft Teams. Registration is required for all training with DCH, and DPH two days prior to training. DCH will NOT accept registration requests made less than 2 business days prior to all 2022 Women's Health Medicaid PE training dates.

TRAINING DATES 2022 Microsoft Teams:

Note: The following are the tentative 2022 training dates for PE WHM.

February 10, 2022 – New Employee Training - 10:00 a.m. to 4:00 p.m.
May 19, 2022 – New Employee and Refresher Training – 9:00 a.m. to 4:00 p.m.
August 18, 2022 – New Employee Training - 10:00 a.m. to 4:00 p.m.
November 10,2022 – New Employee Training - 10:00 a.m. to 4:00 p.m.

All state QPs agencies such as Department of Public Health (DPH), Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) can contact their local DPH office and DCH to register to attend all scheduled Women's Health Training.

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

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

CHAPTER 300 GENERAL PROGRAM REQUIREMENTS

301 Right to Apply

§435.906 Opportunity to apply.

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

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

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

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

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

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

These applicants will be given an application form DMA 632W and informed that their PE WHM application will be denied initially; however, the Medical Assistance application will be reviewed by DFCS and the applicant

will be notified of the final disposition of the Medical Assistance application for EMA.

302 Confidentiality

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

DCH, DFCS, QP/QH are covered entities.

Who is affected by HIPAA?

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

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

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

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

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

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

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

Each applicant will receive the Notice of Privacy Practices Form 5460.

HIPAA resource information can be found at:
http://dch.georgia.gov/hipaa-privacy-notices

303 Non-Discrimination

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

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

304 Notice and Informing

§435.913 Notice of agency's decision concerning eligibility

An applicant is entitled to adequate notice of the results of the PE WHM determination. She must receive notice that her application for Medical Assistance has been forwarded to DFCS for a formal determination of eligibility.

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

305 Fair Hearing Rights

§431.205 Provision of the hearing system

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

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

306 Third Party Liability

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

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

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

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

SOURCES OF THIRD-PARTY LIABILITY INCLUDE:

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

This list is not all inclusive
The information reported by the member should be recorded on the form DMA 285 (Third Party Liability Questionnaire) and included in the PE WHM packet forwarded to DFCS.

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

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

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

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

307 Planning for Healthy Babies (P4HB)

Center for Medicare & Medicaid Services, Special Terms and Conditions

The Center for Medicare and Medicaid Services (CMS) approved a 10-year extension in August 2019 to the Planning for Healthy Babies (P4HB) Demonstration wavier. The P4HB program covers Family Planning services to women ages 18 through 44, income at or below 211 percent of the federal poverty level (FPL) family size based on Modified Adjusted Gross Income (MAGI), who are not covered by major medical insurance, (except dental and vision coverage) including Medicare Part A or Part B of Title XVIII of the Social Security Act and not otherwise receiving benefits under another Medical Assistance program including PeachCare for Kids. P4HB covers Inter-Pregnancy Care (IPC) services, including primary care case management, for eligible women who have delivered a very low birth weight baby (VLBW) within three years of application date. Women, actively receiving Medical Assistance such as Parent Caretaker or ABD SSI and delivered a very low birth weight baby within three years of application, may receive services in the Resource Mother component of P4HB. P4HB is a demonstration that began on January 1, 2011, and as of September 2020, DCH received a 10-year extension for P4HB

The primary goals of the P4HB program are to reduce: Georgia's low birth weight (birth weight less than 2500 grams) and very low birth weight (birth weight less than 1500 grams) rates; the number of unintended and high-risk pregnancies in Georgia; and Georgia's Medical Assistance costs by reducing the number of unintended pregnancies.
There are three levels of service under P4HB – 181 - Family Planning Services, 180 - Inter-Pregnancy Care Services, and 182/183 - Resource Mother Services.

See P4HB MEMO in Appendix M,
All applicants for PE WHM should be informed about P4HB regardless if they are approved or denied.

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

Effective January 2012, DFCS implemented the use of SVES.

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

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

Memo for policy change, "within three years of application date" of very low birth weight (VLBW) baby for any applicant that is applying for Inter-Pregnancy Care 180 and Resource Mother 182 &183.

OTHER COA WITH P4HB

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

CMO PASSIVE ENROLLMENT

PE Women's Health members are immediately enrolled in a Care Management Organization (CMO). The CMO plan will show the next day after approval. All services should be billed under the CMO. If the member's CMO is not the plan of her choice, she has 90 days to change her CMO. If she doesn't, she will not be able to change her CMO for one year. The member can contact Georgia Families by phone at 1-888-GA-Enroll (1-888-423-6765). Calls are received Monday thru Friday from 7 a.m. to 7 p.m. Or she can go on the website at https://www.georgia-families.com. Members who have an emergency or urgent need should contact the DCH Healthcare Program Consultant 3.

MATERIAL

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

CHAPTER 400 APPLICATION AND ENROLLMENT PROCESS

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

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

1. The QP/QH shall conduct an interview with the applicant at which time the provider shall:

   - Advise the applicant she may be eligible for Medical Assistance benefits as a presumptively eligible WHM and as a WHM member for ongoing and retroactive Medical Assistance;

   - Obtain adequate information from the applicant to complete the PE application form DMA 632W, the declaration of citizenship form 216, and the HIPAA form 5460;

   - Determine if the applicant meets the PE WHM eligibility criteria;

2. For any applicant determined presumptively eligible, the QP/QH shall:

   - Perform on-line entry of the application or forward a copy of the completed PE WHM application form DMA 632W to GAMMIS the same day PE WHM application was completed; for data entry by DCH PE Correction box when a QP/QH does not have internet access to GAMMIS;

   - Provide the applicant with a temporary Medical Assistance certificate, or form DMA 634W Approval Notice of Action if the certificate cannot be printed;

   - Obtain adequate information to complete the Third-Party Liability Questionnaire (DMA 285); including applicant's signature in both sections indicated at the bottom of the form, if the applicant has health insurance or some other third-party provider.

- Assist the applicant in completing the regular Medical Assistance application form 94 and obtain the applicant's signature. If the applicant has proof of identity and/or citizenship obtain a copy for the Medical Assistance application. Write "viewed and copied" on each copy, stickers may be used. Refer to section 502 for the complete list of acceptable identity and/or citizenship/immigration documents.

- Forward a copy of the completed PE WHM application form DMA 632W, the signed Medical Assistance application (form 94), form 216 Declaration of Citizenship/Immigration Status, form 5460 HIPAA and the Third Party Liability Questionnaire form DMA 285, if appropriate, to DFCS the same day completion of the PE WHM application.

- Inform the member of the PE time limit and the services covered;

- Provide the member with a copy of the Medical Assistance Guide and fact sheet, "Quick Guide on Women's Health Medicaid", which explains the program and gives additional information;

- Provide the DFCS contact information where her application has been sent;

- Inform the member about Planning for Healthy Babies (P4HB);

- Give the member the Understanding Medical Assistance.

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

- Inform the applicant verbally and in writing via form DMA 634W Denial that she is not presumptively eligible;

- Advise the applicant that if her circumstances change, she may have another determination of PE WHM performed by a QP/QH;

- Assist the applicant in completing the regular Medical Assistance application form 94 and obtain the applicant's signature. If the

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

- Inform the applicant that her application for Medical Assistance form 94 has been forwarded to DFCS for a formal determination of eligibility;

- Forward the signed, DMA 632W and a Medical Assistance application (form 94), the Third-Party Liability Questionnaire (DMA 285), if applicable, form 216 Declaration of Citizenship/Immigration Status and form 5460 HIPAA to the DFCS; copy of the denial DMA 634W form.

- Provide the applicant with the contact information for DFCS. Inform the applicant about Planning for Healthy Babies (P4HB).

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

- Advise the member to contact **Gainwell Technologies Contact Center (1-866-211-0950)**

OR

- Advise the beneficiary to contact the **DFCS** call center at 1-877-423-4746 information concerning their case.

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

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

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

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

CHAPTER 500 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

501 Determination of Budget Group

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

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

In order to determine income eligibility for Presumptive Medical Assistance, it is necessary to determine who is included in the budget group. The budget group is comprised of those members of the household whose needs and income are to be included. The budget group size determines the income limit used.

All household members will not necessarily be members of the budget group. In order to be included in the budget group, there must be a family relationship with the applicant and a financial responsibility (in addition to a residence in the household). The Medical Assistance program holds spouses responsible for spouses and parents responsible for children. Since this program covers only applicants that have met the BCCP requirements, persons included in the budget group must be related to the applicant as her spouse and/or as a child or stepchild to the applicant.

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

BUDGET GROUP COMPOSITION

IF THE APPLICANT LIVES:	AND	THEN INCLUDED:
ALONE OR IN THE HOUSEHOLD OF OTHERS. (THEY MAY BE RELATED TO THE APPLICANT)	HER SPOUSE DOES NOT LIVE THERE	APPLICANT
WITH HER SPOUSE	THEY LIVE ALONE OR IN THE HOUSEHOLD WITH OTHERS. (MAY BE RELATED OR NOT.)	APPLICANT AND SPOUSE
WITH THE OTHER PARENT, FATHER OF HER CHILD(REN), BUT THEY ARE NOT MARRIED	OTHER PARENT AND HIS CHILD(REN) IN THE HOUSEHOLD	APPLICANT AND THEIR COMMON CHILD(REN). DO NOT INCLUDE THE OTHER PARENT OR HIS OR HER CHILDREN
WITH HER CHILD(REN)	THEY LIVE ALONE OR IN THE HOUSEHOLD WITH OTHERS (MAY BE RELATED OR NOT.)	APPLICANT AND HER OTHER CHILD(REN) IF SHE CHOOSES TO INCLUDE THEM. THEY MUST BE HER BIOLOGICAL OR ADOPTED CHILD(REN)
WITH HER SPOUSE AND SHE HAS OTHER CHILD(REN).	HER SPOUSE HAS HIS CHILD(REN) IN THE HOUSEHOLD	APPLICANT, SPOUSE, HER CHILD(REN), COMMON, ADOPTED, AND STEPCHILD(REN) IF SHE CHOOSES TO INCLUDE THEM

Children may be included by the applicant's choice. However, to be included, the child(ren) must be the applicant's biological, adopted or step-child(ren). If the child is not the applicant's child(ren) the child cannot be included in the budget group. The applicant may choose to include some children and exclude others if it is to her benefit to do so.

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

Spouses are responsible for spouses and are included in the budget group. **Exception:** As mentioned above, the only time spouses or children receiving SSI are not included in the budget group.

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

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

Stepparents can include their step-child(ren) in their budget group as long as the child(ren) are under 19 years old.

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

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

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

502 Citizenship/Immigration Status

§435.406 Citizenship and alienage

Policy

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

1. Lawfully admitted immigrants who arrived in the United States **before August 22, 1996**, if they are:

   a) Asylees, refugees, or have been granted parole in the U.S. for at least one year or have had their deportation withheld.

   b) Lawful permanent residents.

   c) Honorably discharged U.S. veterans or active duty military personnel, their spouses, or their unmarried dependent children.

2. Lawfully admitted immigrants who arrived in the United States **on or after August 22, 1996**, if they are:

   a) Asylees, refugees, or have been paroled in the U.S. for at least one year, or if their deportation is being withheld.

   b) Lawful permanent residents who have been credited forty (40) quarters of employment (10 years) under the U.S. Social Security system and have not received any federal means-tested benefits during that time. (The employment test may be met also by the individual's spouse or parent.)

   c) Honorably discharged U.S. military veterans or active-duty military personnel, their spouses, or unmarried dependent children.

   d) Individuals whose immigration status is in accordance with the Victims of Trafficking and Violence and Protection Act or 2000 (Public Law 106-386).

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

4. COFA migrants from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. COFA migrants do not have to meet the 5-year requirement.

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

Definition

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

Procedures

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

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

Acceptable identity and/or citizenship documents:
§435.407 Types of acceptable documentary evidence of citizenship

No Identity Required for these Citizenship Verifications:

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

Identity Required for these Citizenship Verifications:

- US Public Birth Record showing birth in one of the 50 states; District of Columbia; American Territories; or Guam
- US birth certificate or data match with a State Vital Statistic Agency
- Certification of Report of Birth (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the U.S.(FS-240)
- Certification of Birth Abroad (FS-545)
- The United States Citizen Identification Card (I-197 or the prior version I-179)
- American Indian Card (I-872) with the classification "KIC" (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
- Collective Naturalization document/Northern Mariana Identification Card (I-873)
- Final Adoption Decree
- Evidence of civil service employment by the US government
- Official Military record
- Federal or State census record showing US citizenship indicating a US place of birth
- Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs
- A statement signed by the physician or midwife who was in attendance at the time of birth
- One of the following documents created at least 5 years before the application for Medical Assistance showing a US place of birth:
    - Extract of a hospital record on hospital letterhead established at the time of a person's birth
    - Life, health or other insurance record
    - An amended US public birth record
    - Medical clinic, doctor or hospital record indicating a US place of birth
    - Institutional admission papers from nursing home, skilled nursing care facility or other institution

Acceptable Verification of Identity:

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

Applicants should not be denied PE WHM or the right to apply for the program because they cannot provide proof of citizenship/immigrant status. The application should be denied when form 216 indicates that the applicant is not a U.S. Citizen/U.S. National or is not a qualified immigrant. An affirmative entry on the form meets the criteria for citizenship/ immigrant status. If one of these items is completed, the individual will be determined presumptively eligible provided that they met the BCCP requirements; the family income is at or below 200% of the federal poverty level (FPL) income limit; are a Georgian resident; they are under the age of 65; not on Medicare Part A or Part B of Title XVIII of the Social Security Act or Medicaid; and not underinsured.

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

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

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

The applicant must be afforded the full opportunity to apply for PE Medicaid. This means all forms normally given during the course of the application process must be completed. The applicant cannot be given only the form 216 to complete and be denied in the event she does not meet the citizenship/immigrant status requirements.

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

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

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

CHAPTER 600 FINANCIAL ELIGIBILITY REQUIREMENTS

601 Definition of Income

Income is money received by the budget unit from any source. Money received may be earned or unearned. The classification of income as earned or unearned determines the amount of disregards that can be allowed. **Earned income** is compensation received in exchange for services rendered. It may be in the form of wages, salaries, commissions, or self-employment. **Unearned income** is money received for reasons other than for services rendered. It may be in the form of pensions, contributions, gifts, child-support, strike benefits, or interest payments. Income may be received weekly, bi-weekly, semi-monthly, monthly, or some other payment schedule. Income received other than monthly must be converted to a monthly amount in order to perform the income comparison test for PE. The following table shows the conversion factor to use when determining monthly income. This table also appears in Appendix I – Income as part of the income limits table.

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

602 Exempt Income

There are some income types that are not included in the determination of eligibility because they have been defined as excludable under federal statute. Some examples of excluded income are adoption assistance payments, TANF (formerly AFDC) benefits, earnings from the Census Bureau, disaster relief assistance, earned income tax credits, energy assistance payments, and educational grants, loans, or scholarships. Vendor payments are payments made by a third party directly to whom the applicant is indebted to.

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

603 Income Eligibility Limits

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

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

FEDERAL POVERTY GUIDELINES Effective March 1, 2021

FAMILY SIZE	MONTHLY INCOME LIMIT
1	**$2147**
2	**$2904**
3	**$3660**
4	**$4417**
5	**$5174**
6	**$5930**
7	**$6687**
8	**$7444**

EACH ADDITIONAL PERSON ADD $757

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

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

604 Determination of Countable Income

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

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

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

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

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

- $50.00 child support disregard

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

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

605 Earned Income

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

When determining the income to be included from self-employment activities for the income limit, consider net income to be the total profit from the business. Net income is determined by deducting business expenses (those costs directly related to producing the goods or services that are allowable IRS disregards) from the gross income. The applicant's statement regarding gross income, receipts, and costs of doing business, is accepted as establishing the amount of net income to be included in the financial calculation. The applicant may state an amount equal to the net income amount for a stated period. The net income amount from self-employment may receive the $90.00 standard work expense disregard.

Rental income is the only self-employment income that can be budgeted as earned or unearned income, depending on the number of hours an applicant is engaged in property management.
If the applicant is actively involved in property management for at least 20 hours per week, count the net income (gross income less the cost of doing business) as earned income.
If the applicant is not actively involved in property management at least 20 hours per week, count the net income (gross income less the cost of doing business) as unearned income. Unearned income is not entitled to the $90.00 standard work expense disregard.

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

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

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

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

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

606 Unearned Income

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

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

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

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

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

701 On-Line Procedures

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

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

Approvals

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

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

1. Data entry in the appropriate fields certain demographic information contained on the application. When processing over the Internet, the member's identification number will be issued by the system as part of the online process. If already known to the system use the same ID.

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

applicant to present this document to her providers as proof of Medical Assistance eligibility.

3. Retain a copy of the temporary Medical Assistance certificate/DMA 643W Approval in the record, along with the PE WHM application DMA 632W.

4. The same day the PE WHM application is completed, fax/email the PE WHM packet to DFCS. DFCS will review the member's eligibility for ongoing and retroactive Medical Assistance (if requested).

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

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

ERRORS DISCOVERED AFTER PE HAS BEEN SUBMITTED

Providers are encouraged to exercise care when executing the online process. Errors on a Presumptive Eligibility record will cause denials or delays in the payment of claims and prevent a member from receiving services.

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

PE CORRECTIONS: PRESUMPTIVE ELIGIBILITY MANUAL UPDATES

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

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

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

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

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

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

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

702 Manual Approvals

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

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

1. Upon completion of the PE application, email **DCH PE MANUAL UPDATE form** to have it manually updated. Give the PE member form DMA 634W Approval, Notice of Action. The member should present these to their medical care and pharmacy providers.

2. Retain a copy of the temporary Medical Assistance certificate/DMA 643W Approval in the record, along with the PE WHM application DMA 632W.

3. The same day the PE WHM application is completed, fax/email the PE WHM packet to DFCS. DFCS will review the member's eligibility for ongoing and retroactive Medical Assistance (if requested).

PE Packets Include:

Form 632W
DMA 285, required if there is TPL
Form 634W Approval (for approvals that didn't allow a temporary Medical Assistance certificate to print)
HIPAA
Medical Assistance Application form 94
Declaration of Citizenship/Immigration Status form 216 (if not included with form 94)
Certificate of Diagnosis

703 Denied Applications

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

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

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

1. Complete and give the applicant a copy of the **Notice of Action, DMA 634W Denial**. In the case of a denial, this is the **only** form the applicant receives.

2. The same day the PE WHM application is completed, fax/email the PE WHM packet to DFCS.

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

PE Packets Include:

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

APPENDIX A - QUESTIONS & ANSWERS

1. What forms are needed for a PE application?

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

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

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

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

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

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

   No. Anyone who requests PE WHM Medical Assistance must be given an application. Not everyone will be approved for PE, but they must be given an application.

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

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

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

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

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

    - Inform the applicant they have been denied, and why.
    - Give them form DMA 634W Denial Notice of Action and review it with them.
    - Explain the Medical Assistance application form 94 will be given to DFCS to make the Medical Assistance determination, or they can file their application directly with DFCS.
    - Inform the applicant about Planning for Healthy Babies (P4HB).

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

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

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

   QP/QH should screen applications to confirm the applicant is not active on Medicaid. If the member is active on Medicaid, other than P4HB aid categories 180-181, do not complete a PE WHM application online as PE is only temporary Medicaid.

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

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

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

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

   QP/QH should follow the procedures outlined in Chapter 700.

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

    See step by step process in Appendix G - GAMMIS.

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

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

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

See Chapter 600 and Appendix I – Income for Income information.

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

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

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

The right to apply does not mean the application must be completed the same day as they could walk in your office on a Friday at 4:58 p.m. The application should be processed timely for the following business day. Nor does the right to apply to mean everyone is eligible for PE WHM Medicaid.

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

13. How do I order forms?

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

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

If a previously reported third-party resource is no longer valid, i.e., is dropped or canceled, use one of the retained copies of the form and check the “cancellation” block, record the effective date of the cancellation on the line labeled “Policy Termination Date” and send to HMS.

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

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

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

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

Beneficiaries should speak to their MCHB regarding P4HB.

Applicants can contact the following information for questions regarding P4HB:

Phone: 1-877-427-3224
Fax: 912-632-0389
www.gateway.ga.gov

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

Qualified Providers, such as the Department of Public Health, or **Qualified Hospitals** should email pecorrections@dch.ga.gov, regarding any P4HB regulations. Anything regarding claims/codes etc. will need to be handled by the MCHB.

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

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

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

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

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

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

Redetermination for these women are determined yearly for continuous coverage.

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

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

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

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

c. Would an applicant who has never been on WHM because she had private insurance prior to losing her coverage, be eligible for breast

reconstructions and prostheses after mastectomy?

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

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

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

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

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

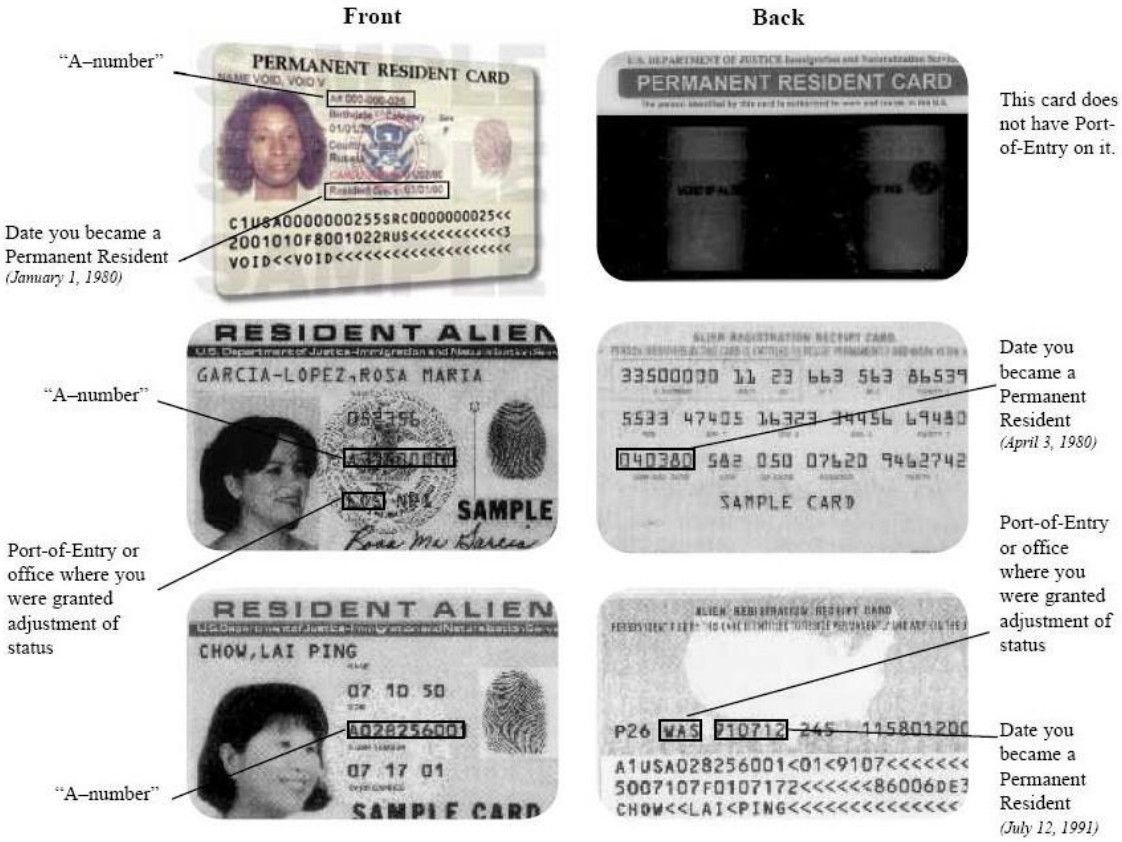
19. When does time as a Permanent Resident begin?

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

Sample: This is what the new US green card looks like. On May 11, 2010, USCIS announced a redesigned Green Card. The Green Card will now be colored green for easy recognition. The Green Card redesign is the latest advance in USCIS's ongoing efforts to deter immigration fraud. State-of-the-art technology incorporated into the new card prevents counterfeiting, obstructs tampering, and facilitates quick and accurate authentication. Beginning May 11, 2010, USCIS will issue all Green Cards in the new, more secure format. USCIS will replace Green Cards already in circulation as individuals apply for green card renewal or green card replacement.


UNITED STATES OF AMERICA
PERMANENT RESIDENT
SPECIMEN TEST V 01 JAN 1920
Surname
SPECIMEN
Given Name
TEST V
USCIS#
000-000-001
Category
RE8
Country of Birth
Utopia
Date of Birth
01 JAN 1920
Sex
F
Card Expires:
08/21/07
Resident Since:
08/21/07
Test V. Specimen


I-551
00000001
SPECIMEN,
TEST V
DOB 01/01/20 EXP 08/21/07
CARD# SRC0002000001
A# 000-000-001
Test V. Specimen
If found, drop in any US Mailbox. USPS: Mail to USCIS, PO Box 82521, Lincoln, NE 68501-2521
C1USA0000000011SRC0000000001<<
2001012F0708214UTP<<<<<<<<<<<6
SPECIMEN<<TEST<VOID<<<<<<<<<<<



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

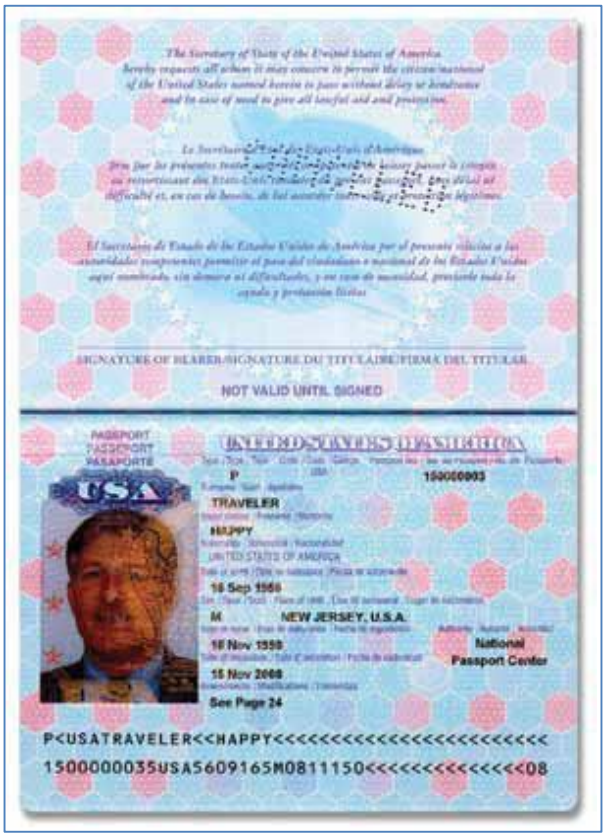
20. What is a passport?

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

Current U.S. Passport



Older U.S. Passport



U.S. Passport Card

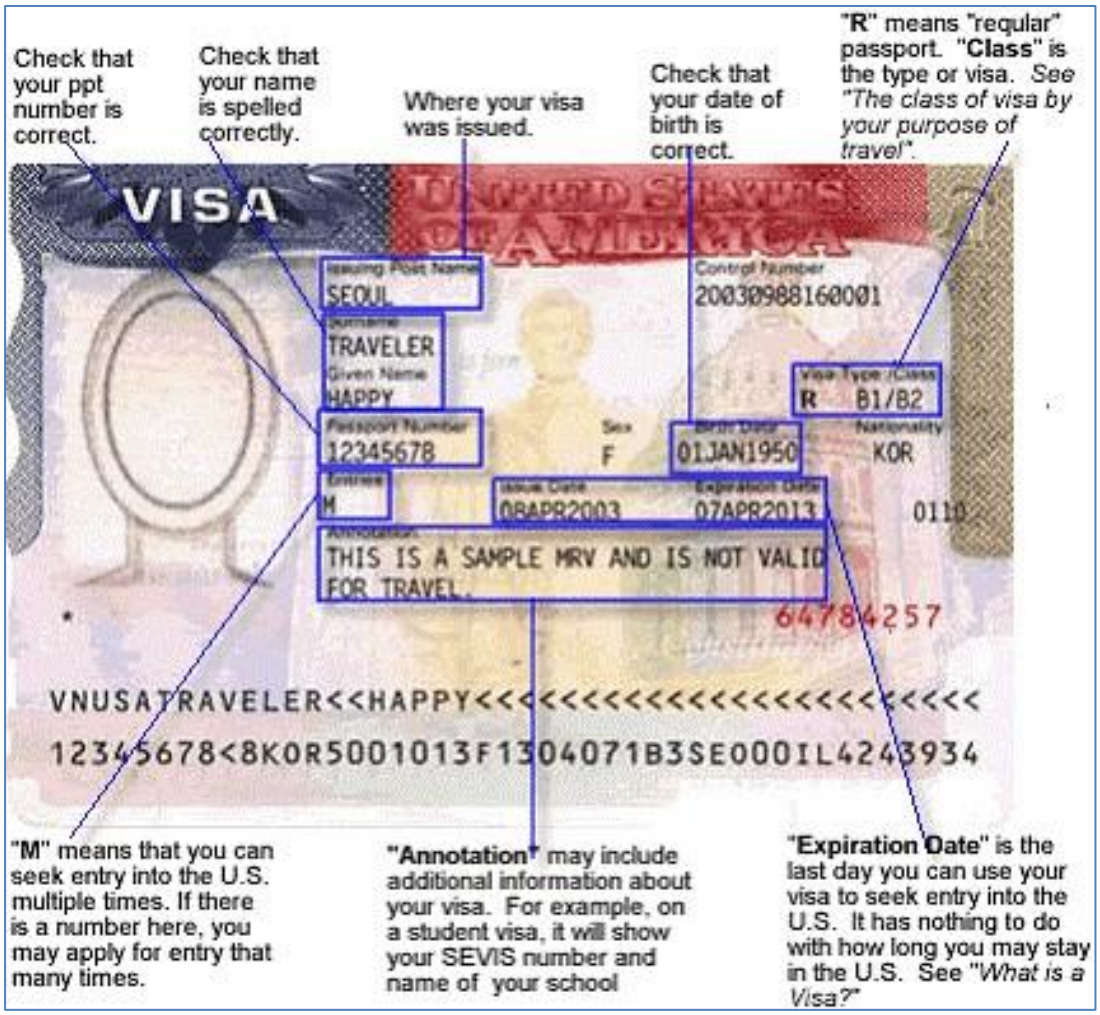
The U.S. Department of State began producing the passport card in July 2008. The passport card is a wallet-size card that can only be used for land and sea travel between the United States and Canada, Mexico, the Caribbean, and Bermuda.





21. How do I read and understand a visa?

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



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

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



When an immigrant has been granted admission into the U.S. by an Immigration Inspector at an authorized Port of Entry, he/she will be issued a 1-94, ARRIVAL/DEPARTURE RECORD, which is stapled to a page in the passport. This document will explain how long the bearer may remain and the terms of admission.





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

Student Visa Overview

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

1. F1 Visa: Academic Studies

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

2. J Visa: Academic Studies as an Exchange Visitor

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

3. M Visa: Non-Academic or Vocational Studies

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

Business Visa

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

Work Visa

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

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

Visitor VISA

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

APPENDIX C- CLASS OF ASSISTANCE

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

140 - PCK/MA IVB Children	Former Peachcare for Kids® members with IVB Medical Assistance placement. Available to children from birth through the last day of the month of the child's 19th birthday.
147- Family Medically Needy Spend Down Child	Family Medical Assistance Medically Needy (FM-MN) provides Medical Assistance for children under 19 years of age whose BG income exceeds limits for all Family Medical Assistance and PeachCare for Kids®.
148 - Pregnant Woman Medically Needy Spend Down	Family Medical Assistance Medically Needy (FM-MN) provides Medical Assistance for pregnant women whose BG income exceeds limits for all Family Medical Assistance and PeachCare for Kids®.
170 - **194** - **197** Pregnant Woman	Medical Assistance to eligible pregnant women who meet eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).
171 - 172 - 195 - 196 Children Under 19 Years of Age	Medical Assistance to eligible children through the month in which the child turns 19 years of age who meet eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).
177 - Family Planning Demonstration	The original Family Planning Demonstration no longer active
180 - P4HB IPC	Planning for Healthy Babies IPC
181 - P4HB Family Planning	Planning for Healthy Babies Family Planning Demonstration
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 Medical Assistance1972 COLA
221 - 222 - 223	ABD Disabled Widow(er) 1984 COLA
224 -225 - 226 Pickle	Pickle (PL 94-566) is a class of assistance (COA) that provides for an individual or couple who correctly received RSDI and SSI or a Mandatory State Supplement (MSS) concurrently and became ineligible for SSI or MSS because of the RSDI COLAs.
227 - 228 - 229 **Disabled** Adult Child	Disabled Adult Child (PL 99-643) is a class of assistance (COA) that provides Medical Assistance for an individual 18 or older who had his/her SSI terminated on or after 7/1/87 because of an entitlement or an increase in RSDI income received as a disabled adult child.

230 - 231 - 232 Disabled Widow(er) **Age 50-59** **Age 60-64**	The Disabled Widow(er) class of assistance (COA) provides Medical Assistance for an individual whose SSI was terminated because of his/her entitlement to an RSDI disabled widow(er) benefit.
236 - 237- 238	ABD three (3) months prior Medicaid
245 Women's Health Medical Assistance(WHM)	Ongoing WHM for women with breast and/or cervical cancer.
246 GMWD	Georgia Medical Assistance for Workers with Disabilities (GMWD), offers people with disabilities, who are working, the opportunity to pay a small premium for health care coverage through Medicaid. GMWD provides Medical Assistance coverage to workers with disabilities who are employed but are no longer eligible for SSI due to increased earnings. The individual must have at one time been a recipient of SSI or SSA disability or been determined disabled.
247 - Disabled Child 1996	Former SSI-Disabled Child, for children who were terminated from SSI due to a new definition of disability according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
250 Deeming Waiver	ABD Katie Beckett - Medical Assistance for children under 18 years of age that qualify for institutional care but stay at home.
251 ICWP	Independent Care Waiver Program provides in-home care to individuals who are Severely Physically Disabled or who have Traumatic Brain Injuries. The individuals cannot physically care for themselves and require assistance for daily functioning.
256 NOW	New Options Waiver (NOW) offer services and support that enable eligible individuals to remain living in their own or family home and participate in community life
257 COMP	Comprehensive Supports Waiver Program (COMP) provides residential care for individuals with intellectual and related developmental disabilities (I/DD) who require comprehensive and intensive services; need out of home residential support and supervision or intensive levels of in-home services to remain in the community.
258 CBAY	The Community-Based Alternatives for Youth (CBAY) Waiver Program allows Medical Assistance eligible youth who would otherwise have been placed in Psychiatric Residential Treatment Facilities (PRTF) or were transitioned from PRTFs to receive community-based services thus preventing re-institutionalization.

259 CCSP	Community Care Services Program is designed to provide in home and community-based services to individuals. These individuals meet the criteria for nursing home placement but choose to remain in a residential home situation.
280 - 281 - 282	ABD Hospice
289 - 290 - 291	ABD Institutional Hospice
All 300 codes	SSI Medicaid
All 400 codes	SSI Ex-Parte Medicaid
All 500 codes	Refugee Medicaid
660 QMB	Qualified Medicare Beneficiaries (QMB) is a Q Track class of assistance (COA) that provides a Medicare supplement to individuals who meet financial criteria based on the Federal Poverty Level (FPL).
661 SLMB	Specified Low-Income Medicare Beneficiaries (SLMB) is a Q Track class of assistance (COA) that pays the monthly premium for Medicare Supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal poverty level (FPL).
662 QI1	Qualifying Individuals – 1 (QI-1) is a Q Track class of assistance (COA) that pays the monthly premium for Medicare supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal Poverty Level (FPL). Eligibility criteria are identical to SLMB except that the coverage is time-limited depending on available State funds and the income limit is higher than the SLMB limit.
790 - 791 - 792 - 793 PeachCare for Kids®	PeachCare for Kids® (PCK) provides Medical Assistance for children who are financially ineligible for Medical Assistance. Available to children from birth through the last day of the month of the child's 19th birthday.
800 Presumptive Women's Health Medicaid	Presumptive WHM for women with breast and/or cervical cancer determined by Qualified providers/Qualified hospitals only.
835 Presumptive Newborn	Newborn Medical Assistance is given to deemed newborns by 378 providers only.
864 Presumptive Pregnant Woman	Presumptive Pregnant Medical Assistance for a pregnant woman determined by Qualified providers/Qualified hospitals only. **(Effective 02/26/15)**
865 Presumptive Pregnant Woman	Presumptive Pregnant Medical Assistance for a pregnant woman determined by Qualified providers/Qualified hospitals only. **(Discontinued 02/26/15)**
801 Presumptive Parent/Caretaker Adult Medicaid	Presumptive Parent/Caretaker Medical Assistance benefits for eligible adults that have a qualifying child.

802 Presumptive Parent/Caretaker Child Medicaid	Presumptive Parent/Caretaker Medical Assistance for eligible children up to age 19 and the adult(s) who are responsible for those children.
806 Presumptive Child(ren) under 19 Years of Age	Presumptive Medical Assistance to eligible children through the month in which the child turns 19 years of age who meet eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).
852 Presumptive Former FosterCare	Continuation of FosterCare Medical Assistance for former foster care beneficiaries that aged out of FosterCare Medical Assistance or CHAFEE Medical Assistance and are no longer eligible for FosterCare Medical Assistance and are under 26 years of age.

Appendix E - Examples

Presumptive Eligibility Period

1. Ms. Smith applies in your office on 2/11/XX and is approved. Her PE eligibility period begins 02/11/XX and will end on the last day of the following month, 3/31/XX or until a decision is made by the Right from the Start Medical Assistance Group, Morrow Team. The PE will end on the date that Morrow makes an eligibility determination in Gateway.

2. Ms. Washington applies in your office on 5/1/XX; her PE period would be 5/1/XX through 6/30/XX.

3. Ms. Hernandez applies 12/31/XX in your office. Her PE period will start 12/31/XX and end 1/31/XX.

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

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

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

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

Budget Unit Composition

1. Sally Jones, age eighteen, has two children under the age of three who live with her in her mother's home. Two of Sally's brothers live in the home also. Sally visited her local Department of Public Health that verified she met the BCCP requirements. The father of her children is not in the home. Who is included in the budget unit?

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

2. Marcy Brown lives with her husband, her daughter, two mutual children, and his son. She has met the BCCP requirements. Marcy is employed and earns $2100.00, per month. Her husband is employed as a machinist and earns $3128.00, per month. Marcy receives $875.00, per month, child-support for her daughter. Who is included in the budget unit?

   a. Marcy is included in the budget unit and her husband is included because he is in the household and financially is responsible for Marcy.
   b. Marcy has chosen to include her daughter, her two mutual children and her stepson. The household budget group is six. Marcy can include her stepson in her budget group per policy because her stepson meets the budget group composition and the degree of relationship.
   c. She has decided to exclude her daughter and the daughter's income. Therefore, the budget unit size is five, Marcy, her husband and their two mutual children and Marcy's stepson.
   d. If Marcy had chosen to include her daughter, the budget unit size would have been six, and the daughter's child support income would have been included in the income comparison test.

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

   a. Jane's budget group can be counted as two, which includes her and her son. Her boyfriend is not included as he is not a spouse and he is not financially responsible for Jane. He is also not the biological father of her son
      .

b. Her son can be included in the budget group to increase the income limit for Ms. Smith; however, he can only stay in the budget group until the month he turns nineteen years old.
   The month following his 19th birthday he is no longer allowed to be included in the budget group per policy and may affect continued eligibility for the member.
c. The son should be referred to the Social Security Administration to apply for disability benefits. When Jane completes the Medical Assistance application form 94, DFCS will determine if he is Medical Assistance eligible.

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

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

EFFECTIVE FOR SERVICES BEGINNING: April 1, 2019 (MONTH DAY YEAR)

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

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

999988765432
MEDICAL ASSISTANCE IDENTIFICATION NUMBER

April 1 - May 31, 2019
VALID FOR LISTED MONTH ONLY

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAL ASSISTANCE

APPLICANT'S NAME: Lucy White
MAIDEN NAME: Franklin
HEALTH INSURANCE: ☐ YES ■ NO
APPLICANT'S ADDRESS: 289 First Street
TELEPHONE NUMBER: (404) 565-6565
APARTMENT/LOT NUMBER: G5
SOCIAL SECURITY NUMBER: 098-76-5432 (Optional)
APPLICANT'S RECORD: 123ABC
CITY: Henry STATE: GA ZIP CODE: 30281 COUNTY OF RESIDENCE: Henry
DATE OF INTERVIEW: 04/01/2019

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

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAL ASSISTANCE AND THAT THE MORROW RIGHT FROM THE START MEDICAL ASSISTANCE (MRSM) GROUP WILL DETERMINE MY CONTINUING ELIGIBILITY.
I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IN THE UNITED STATES AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME.
I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).
I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH ARSM MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY.
I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS.

04/01/2019 (DATE OF APPLICATION) — Lucy White (APPLICANT'S SIGNATURE)

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

04/01/2019 (DATE OF COMPLETION) — Lorraine Russell (COMPLETED BY (PLEASE PRINT)) — RN (TITLE)

(404) 651-9978 (DIRECT PHONE NUMBER) — Lorraine Russell (SIGNATURE OF INDIVIDUAL COMPLETING)

FORM 632W (10/24/2017)

TOTAL GROSS INCOME = 0
CHILD SUPPORT DISREGARD = 0
NUMBER IN FAMILY = 3
POVERTY INCOME LEVEL = 3,555
TOTAL FAMILY NET INCOME = 0

Applicant is ■ ELIGIBLE or ☐ INELIGIBLE for PE WHM

PROVIDER CERTIFICATION:

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

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

Lorraine Russell (QUALIFIED PROVIDER SIGNATURE) — RN (TITLE)

Henry DPH (QUALIFIED PROVIDER NAME) — 2332323214P (QUALIFIED PROVIDER ID NUMBER)

QUALIFIED PROVIDER ADDRESS: 135 Henry Pkwy.
McDonough, GA 30253

Income

Michele Brown lives with her husband, her daughter, and three mutual children. She has met the BCCP requirements. Michele is employed and earns $2622.00, per month. Her husband is employed as a machinist and earns $2730.00, per month. Michele receives $851.00, per month, child support for her daughter. Determine financial eligibility.

$ 2622.00	Mrs. Brown's earned income
$ -90.00	Standard work expense disregards
$ 2532.00	
$ 851.00	Child Support
$ 3383.00	
$ -50.00	Child Support Disregard
$ 3333.00	Mrs. Brown's net income

$ 2730.00	Mr. Brown's earned income
$ -90.00	Standard work expense disregards
$ 2640.00	Mr. Brown's net income

$ 3333.00	Mrs. Brown's net income
$ 2640.00	Mr. Brown's net income
$ 5973.00	Total Household Income for BG of 6
	BG of 6 Income Limit = $5930
	Not PE eligible for Household of 6

Calculate everyone in the BG home first, if the applicant is eligible for all household members then use everyone allowed by policy. The total household net income must be equal to or less than the income limit for the BG.
In this case, since everyone included causes her to be ineligible, let's explore who we can remove. The best place to start is with BG members that have income; however, a spouse cannot be removed. Her daughter has child support if that were eliminated it would create a BG of 5.

$ 2622.00	Mrs. Brown's earned income
$ -90.00	Standard work expense disregards
$ 2532.00	Mrs. Brown's net income

$ 2730.00	Mr. Brown's earned income
$ -90.00	Standard work expense disregards
$ 2640.00	Mr. Brown's net income

$ 2532.00	Mrs. Brown's net income
$ 2640.00	Mr. Brown's net income
$ 5172.00	Total Household Income for BG of 5
	BG of 5 Income Limit = $5174
	PE eligible for Household of 5

Mrs. Jones has met the BCCP requirement. She lives with her husband, their 15-year-old son, and 3-year-old daughter. Mrs. Jones earns $421.00, per month, as a cashier. Mr. Jones works as a security guard and earns $960.00, per month. Their son is a full-time student and earns $75.00, per month, by delivering newspapers one hour each morning before school. Mrs. Jones pays $250.00, per month, for their daughter to attend the Jack and Jill Nursery School. Determine financial eligibility.

$ 421.00	Mrs. Jones' earned income
$ -90.00	Standard work expense disregards
$ 331.00	
$ -175.00	Child care disregard for three-year-old
$ 156.00	Mrs. Jones' net income
$ 960.00	Mr. Jones' earned income
$ -90.00	Standard work expense disregards
$ 870.00	Mr. Jones' net income
$ 156.00	Mrs. Jones' net income
$ 870.00	Mr. Jones' net income
$ 1026.00	Total Household Income for BG of 4
	BG of 4 Income Limit = $4417
	PE eligible for a BG of 4

Net income is less than the income limit, so Mrs. Jones is eligible for Presumptive Eligibility. When Mrs. Jones completes the Medical Assistance application form 94, DFCS will determine if she is Medical Assistance eligible.

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

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

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

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

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

If Mrs. Smith chooses to exclude both children:

$ 400.00	Mrs. Smith's earned income
$ -90.00	Standard work expense disregards
$ 310.00	Total net income for BG of 1
	BG of 1 income limit = $2147
	PE eligible for a BG of 1

If Mrs. Smith chooses to include the children:

$ 400.00	Mrs. Smith's earned income
$ -90.00	Standard work expense disregards
$ 310.00	
$ 300.00	Child support received for Jane
$ 610.00	
$ 120.00	Child support received for Debbie
$ 730.00	
$ -50.00	Child- support disregard
$ 680.00	Total net income
	BG of 3 income limit = $3660
	PE eligible for a BG of 3

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

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

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

Conversion Factor

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

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

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

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

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

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

SPECIFIED RELATIVE

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

Susan gets married to Tommy. Tommy has three daughters, Bobbi Jean, Krissy, and Heaven Leigh. Bobby and Jessica move back in the home. Susan has met the BCCP requirements. Susan's budget group must include her spouse, Tommy. Susan can add Bobby to the budget group and Tommy's three daughters as they would be her stepdaughters.

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

SSI FEDERAL PAYMENT AMOUNTS FOR 2021

Recipient	SSI Monthly Amount 2021	SSI Yearly Amount 2021
Eligible Individual	$794	$9,528
Eligible Couple	$1,191	$14,292

Appendix F: FORMS Table of Contents

Form Number	Form Name	Instructions	Revision Date
DMA 632W	PE WHM APPLICATION	DMA 632Wi	09/21
DMA 632W	PE WHM Application Page 2		09/21
94	ENGLISH MEDICAL ASSISTANCEAPPLICATION	94i	06/16
94SP	SPANISH MEDICAL ASSISTANCEAPPLICATION		06/16
DMA 634W	APPROVAL NOTICE OF ACTION	DMA 634i	07/21
DMA 634W	DENIAL NOTICE OF ACTION	DMA 634i	09/21
	CERTIFICATION OF DIAGNOSIS		07/21
DMA 285	HEALTH INSURANCE QUESTIONNAIRE	DMA 285i	01/06
216	ENGLISH DECLARATION OF CITIZENSHIP	216i	10/18
216SP	SPANISH DECLARATION OF CITIZENSHIP		10/18
5460	ENGLISH HIPAA	5460i	01/21
5460SP	SPANISH HIPAA		01/21
	QUICK GUIDE ON WOMEN'S HEALTH MEDICAL ASSISTANCE		09/21
	WOMEN'S HEALTH MEDICAL ASSISTANCE PROGRAM FACT SHEET		09/21
	PE Manual Updates		08/21
	SSI Pregnant Woman Update		01/17
DMA 632WQP	Statement of Treatment		07/21
	Georgia Families		05/21

INSTRUCTIONS ON FORMS

PRESUMPTIVE ELIGIBILITY WHM APPLICATION:

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

The form is divided into three parts. The top third of the form reflects demographic information of the member and the month for which the card is valid. The middle third of the form reflects budget group information including income data. The bottom third of the form consists of the sworn statement of the applicant and the provider, as well as, the budget group income information.

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

Completion of Individual Items

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

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

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

EFFECTIVE FOR SERVICES BEGINNING _____
MONTH DAY YEAR

GAINWELL TECHNOLOGIES
P.O. BOX 105200
TUCKER, GA 30085-5200

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



_____
MEDICAL ASSISTANCE IDENTIFICATION NUMBER

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAL ASSISTANCE

_____
PE ELIGIBILITY PERIOD

APPLICANT'S NAME: _____ MAIDEN NAME: _____ HEALTH INSURANCE: ☐ YES ☐ NO

APPLICANT'S ADDRESS: _____ TELEPHONE NUMBER: _____ APPLICANT'S RECORD NUMBER: _____

APARTMENT/LOT NUMBER: _____ SOCIAL SECURITY NUMBER: _____ (Optional) DATE OF INTERVIEW: _____

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

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

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILIY FOR MEDICAL ASSISTANCE. IT WILL END WHEN THE DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) DETERMINES MY ELIGIBILITY OR INELIGIBILITY, BUT NO LATER THAN THE LAST DAY OF THE MONTH FOLLOWING THE MONTH OF THE PE APPROVAL. DFCS WILL DETERMINE MY CONTINUTING ELIGIBILITY.

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

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

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

_____ _____
DATE OF APPLICATION APPLICANT'S SIGNATURE

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

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

_____ _____
DIRECT PHONE NUMBER SIGNATURE OF INDIVIDUAL COMPLETING FORM

SUBTOTAL NET INCOME = _____ CHILD SUPPORT DISREGARD= _____

NUMBER IN BUDGET GROUP = _____ TOTAL FAMILY NET INCOME = _____

POVERTY INCOME LEVEL = _____

Applicant is ☐ ELIGIBLE or ☐ INELIGIBLE for PE WHM.

PROVIDER CERTIFICATION:

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

HER DIAGNOSIS MET THE BCCP IN GEORGIA. I HAVE OBTAINED A SIGNED MEDICAL ASSISTANCE APPLICATION FROM THE APPLICANT AND HAVE EMAILED TO WOMENSHEALTH@DHS.GA.GOV OR FAXED TO 912-377-1134.

_____ _____
QUALIFIED PROVIDER SIGNATURE TITLE

_____ _____
QUALIFIED PROVIDER NAME QUALIFIED PROVIDER ID NUMBER

QUALIFIED PROVIDER ADDRESS: _____

632W (09/02/2021)

GAINWELL TECHNOLOGIES
P.O. BOX 105200
TUCKER, GA 30085-5200

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



PRESUMPTIVE ELIGIBILITY WOMEN'S HEALTH MEDICAL ASSISTANCE PAGE 2

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

*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.

HOUSEHOLD CONTINUED	DATE OF BIRTH MM/DD/YYYY	* RACE	GENDER	RELATION TO APPLICANT	MONTHLY GROSS INCOME				MONTHLY DISREGARDS		MONTHLY NET INCOME
FIRST NAME MI LAST NAME SUFFIX					TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	STANDARD WORK DISREGARD	DEPENDENT CARE DISREGARD	

632W Page 2 (09/02/2021)

SPECIAL NOTE TO MEMBER:

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

INSTRUCTIONS TO MEMBER:

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

INSTRUCTIONS TO PROVIDER:

Medical assistance services are to be provided in accordance with the Department of Community Health Plan. Verify eligibility on GAMMIS or by using the IVR system. Certification must be requested each time a service is requested. Always check for other proof of identity. Enter the complete member number as shown for the person receiving the service on the medical assistance claim form. Contact GAMMIS on questions regarding member eligibility.

NOTICE TO OUT OF STATE PROVIDER:

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

NOTICE TO MEMBER:

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

MEDICAL ASSISTANCE APPLICATION FORM 94:

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

COMPLETION OF INDIVIDUAL ITEMS:

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

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

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept.

Check block(s) that apply to you:

- ☐ Pregnant Woman
- ☐ Women's Health
- ☐ Child under 19
- ☐ Parent Caretaker
- ☐ Chafee Independence Program Medicaid

Where you in foster care on your 18th birthday? Yes No, in which state?_____

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

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

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

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

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

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

Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? ☐ Yes ☐ No If yes, have you received Women's Health Medicaid previously? ☐ Yes ☐ No

Form 94 (09/16)

INCOME, TAX FILER and DEPENDENT CARE

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

Income	Gross Amount per Pay Check (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving
Wages/Earnings			
Current Employer:			
Wages/Earnings			
Current Employer:			
Social Security Income/SSI			
Worker's Compensation			
Pensions or Retirement Benefits			
Child Support/ Contributions			
Unemployment Benefits			
Other Income, please specify:			

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ☐Yes ☐No
   If YES, who? (List each person who plans to file)
2. Will any of the tax filers listed file jointly with a spouse? ☐Yes ☐No
   If YES, please list spouses name: _____
3. Will any of the filers claim any dependents on their tax return? ☐Yes ☐No If YES, please list the names of dependents: _____
4. Will anyone be claimed as a dependent on someone else's return? ☐Yes ☐No If YES, please list the name of the tax filer and the dependent: _____

How is the tax dependent related to the tax filer? _____

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

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

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

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

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

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

Signature (Required): _____ Date: _____

Form 94 (09/16)

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

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

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

CHILDREN SEEKING BENEFITS

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

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

_____ _____
SIGNATURE (DATE)

ADULT(S) SEEKING BENEFITS

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

I, _____ attest to the best of my knowledge to the identity of the adult(s) listed
(PRINT NAME)
above and certify under penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (DATE)

Form 216 ENG-SP Rev. 09/18

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

SOLICITUD DE MEDICAID

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

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

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

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

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

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

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

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

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

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

Form 94SP (09/16)

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

INGRESOS, RECURSOS y GUARDERÍAS

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

Ingresos	Cantidad bruta por cheque de pago (Cantidad antes de deducciones)	¿Con qué frecuencia? (Semanal, cada dos semanas, mensual, etc?)	Nombre de la persona que los recibe
Salarios / ganancias			
Empleador actual:			
Salarios / ganancias			
Empleador actual:			
Ingresos del Seguro Social / SSI			
Compensación al Trabajador			
Pensiones o Beneficios de Jubilación			
Manutención de Menores/Contribuciones			
Beneficios de desempleo			
Otros ingresos, por favor, especifique:			

Impuestos Filer Estado

1. Tiene planes de presentar una declaración de impuestos federales el próximo año? (Todavía puede solicitar un seguro médico, incluso si usted no presentar una declaración de impuestos federales.)
☐ Sí En caso afirmativo, responder a las preguntas a-c
☐ No si no, pase a la pregunta c
2. Va a presentar conjuntamente con su cónyuge? ☐ Sí ☐ No
En caso afirmativo, nombre del cónyuge : _____
3. Va a reclamar dependientes en su declaración de impuestos? ☐Sí ☐ No en caso afirmativo lista de sus dependientes: _____
4. Va a ser reclamado como dependiente en la declaración de impuestos de otra cosa de alguien? ☐ Sí ☐ No
En caso afirmativo , indique el nombre del archivador de impuestos : _____
5. Cómo es su relación con el contribuyente de impuestos? _____
Estas embarazada? ☐ Sí ☐ No en caso afirmativo, cuántos bebés se espera que durante este embarazo?

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

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

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

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

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

Firma (Obligatoria): _____ Fecha: _____

Form 94SP (09/16)

DECLARACION DE CIUDADANIA/ESTADO MIGRATORIO

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

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

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

NIÑOS QUE SOLICITAN BENEFICIOS

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

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

_____ _____
FIRMA FECHA

ADULTO(S) QUE SOLICITAN BENEFICIOS

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

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

_____ _____
FIRMA FECHA

Formulario 216 ENG-SP REV. 09/18

NOTICE OF ACTION Form DMA 634W:

634W Approval

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

634W Denial

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

COMPLETION OF INDIVIDUAL ITEMS:

Complete the top part of the form showing identifying information:

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

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

Enter whichever reason is correct.

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

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor — Caylee Noggle, Commissioner

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

NOTICE OF ACTION

Presumptive Eligibility for Women's Health Medicaid

Date

Name _____

Address _____

City _____ State GA Zip Code _____

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

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

When you applied for PE Women's Health Medicaid, you may also have applied for ongoing/retroactive Medicaid. Your Medicaid application will be sent to the Division of Family and Children Services (DFCS). DFCS will make the decision for your regular Medicaid benefits and notify you by mail.

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

Signature of Qualified Provider

Qualified Provider Address

Title

Phone Number

Qualified Provider ID Number

DMA 634W (Approval) Revised 07/15/21

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

Equal Opportunity Employer

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Caylee Noggle, Commissioner

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

NOTICE OF ACTION

Presumptive Eligibility for Women's Health Medicaid

Date

Name

Address

City State GA Zip Code

☐ **PRESUMPTIVE ELIGIBILITY DENIED**

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

The reason for denial is: Choose Item

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

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

Signature of Qualified Provider

Qualified Provider Address

Title

Phone Number

Qualified Provider ID Number

DMA 634W (Denial) Revised 09/02/21

CERTIFICATION OF DIAGNOSIS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Caylee Noggle, DCH Commissioner
Kathleen E. Toomey, DPH Commissioner

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

Women's Health Medical Assistance Program

Certification of Diagnosis

Client Name: _____

Client SS #: _____
(optional)

Clinic Name: _____

Diagnosis (**Biopsy**) Date: _____

Diagnosis: _____

Physician's Signature: _____ Date: _____

INSTRUCTIONS:

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

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

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

Revised 07/16/21

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

PURPOSE

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

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

PREPARATION

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

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

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

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

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

EXAMPLE OF FORM DMA 285 COMPLETED:

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

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

TYPE OF CASE: ☒ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
(Check all that apply) ☐ HIPP 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 Absent Parent? ☐ YES ☒ NO

Names of Covered Individuals in Household (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one) Policy Holder	Spouse	Child	Step-child	Other	Date Of Birth
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 (Address) Columbus (City) GA (State) 31392 (Zip)
Mr. X Husband Member (Policyholder Name) 987-65-4321 (Policyholder SSN) ABC123 (Policy Number) 04/19/65 (Policyholder DOB)
12/31/00 (Policy Effective Date) (Policy Termination Date)
ABC Construction (Employer Name) 706-321-5555 (Telephone Number)
211 Maple Drive (Employer Address) LaGrange (City) GA (State) 34567 (Zip)

Types of Coverage (circle those which apply)
01 – HOSPITAL INPT. 15 – 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.
Signed Applicant's Signature Date 01/01/xx
Member or Authorized Person

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

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

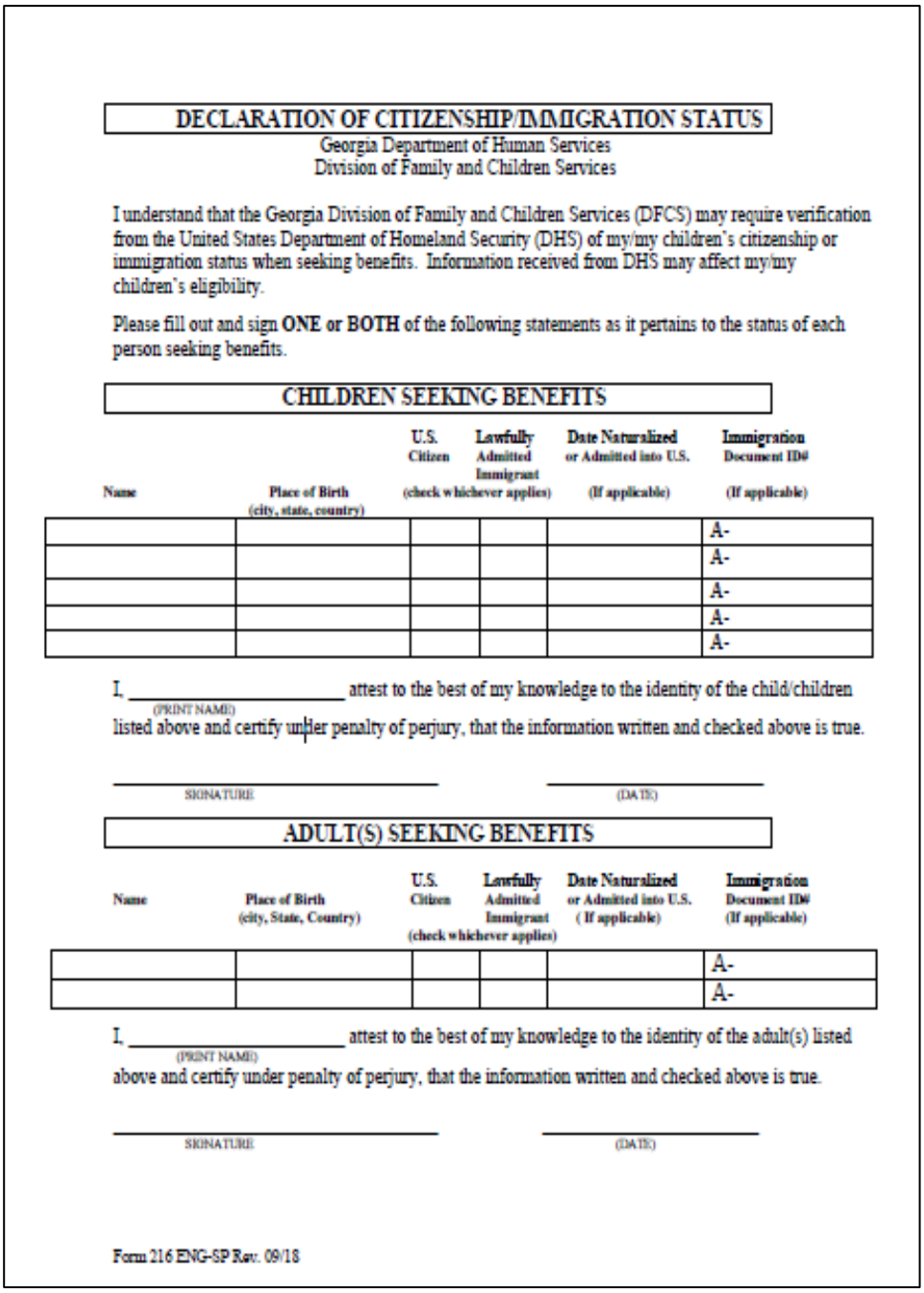
DMA-285-REV. (01/06)

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

Declaration of Citizenship/Immigration Status:

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

This is page 3 of the 94 Medical Assistance application.



DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

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

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

CHILDREN SEEKING BENEFITS

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

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

_____ _____
SIGNATURE (DATE)

ADULT(S) SEEKING BENEFITS

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

I, _____ attest to the best of my knowledge to the identity of the adult(s) listed
(PRINT NAME)
above and certify under penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (DATE)

Form 216 ENG-SP Rev. 09/18

DECLARACION DE CIUDADANIA/ESTADO MIGRATORIO

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

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

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

NINOS QUE SOLICITAN BENEFICIOS

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

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

_____ _____
FIRMA FECHA

ADULTO(S) QUE SOLICITAN BENEFICIOS

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

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

_____ _____
FIRMA FECHA

Formulario 216 ENG-SP REV. 09/18

Notice of Privacy Practices form 5460:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
The Privacy Ruling was published in the Federal Register on December 28, 2000. The U.S. Department of Health and Human Services' Office for Civil Rights is responsible for enforcing this rule. There are civil and criminal penalties for violating this rule, including fines up to $250,000 and imprisonment for up to 10 years.

The privacy regulation has three major purposes:

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

Each time an application is submitted for PE a new HIPAA form 5460 will be given to the applicant to be completed regardless of the PE application is approved or denied.

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Date: January 18, 2021

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 your 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 protected 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 Privacy Officer at the contact information below.

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 information technology 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 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, counterintelligence, 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 OUT:

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 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 Health Information to disaster relief organizations that seek your 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 Health Information will be made only with your written authorization:

1. Uses and disclosures of Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Health Information.

Other uses and disclosures of 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 with an authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer. Upon receipt, DHS will no longer disclose 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 below referenced Privacy Officer. DHS has up to 30 days to make your 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 of 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 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 Health Information in the form or format you request if it is readily producible in such form or format. If the 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 below referenced 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 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 Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your 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 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 Privacy Officer. You may also obtain a copy from the DHS website, on the Office of General Counsel homepage:
https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel

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 and on the website at https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel. 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
Privacy Officer
2 Peachtree Street NW, 29th Floor
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 Privacy Officer. Please include your name, phone number, case number and a description of the complaint. **You will not be penalized for filing a complaint.**

You may also file with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). For more information on HIPAA privacy requirements, HIPAA electronic transactions, and code sets regulations and the proposed HIPAA security rules, please visit U.S. Department of Health and Human Services web site at https://www.hhs.gov/hipaa/index.html.

If you have questions about your health or your health care services, you should contact your health care provider (physician, pharmacy, hospital or other medical provider).

[SIGNATURE PAGE TO FOLLOW]

Signature Page

If you would like to acknowledge receipt of this DHS HIPAA Notice of Privacy Practices, please sign below, and return this page to the address below.

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

_____ _____

Signature Date

_____

Print Name

Return Address:

[Insert Local Address here]

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

Fecha de entrada en vigencia: 18 de enero de 2021

ESTE AVISO DESCRIBE CÓMO SE PUEDE UTILIZAR Y DIVULGAR LA INFORMACIÓN MÉDICA SOBRE USTED Y CÓMO USTED PUEDE ACCEDER A ESTA INFORMACIÓN.

LEA ESTE AVISO CON ATENCIÓN.

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

OBLIGACIONES DEL DEPARTAMENTO DE SERVICIOS HUMANOS:

La ley exige al DHS lo siguiente:

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

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

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

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

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

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

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

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

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

SITUACIONES ESPECIALES:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SE REQUIERE SU AUTORIZACIÓN PARA OTROS USOS Y DIVULGACIONES:

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

1. Usos y divulgaciones de Información Médica protegida a fines de comercialización.

2. Divulgaciones que constituyan la venta de su Información Médica protegida.

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

SUS DERECHOS:

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

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

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

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

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

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

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

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

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

Derecho a una copia en papel de este aviso. Tiene derecho a recibir una copia impresa de este aviso. Puede solicitar una copia de este aviso en cualquier momento. Incluso si ha aceptado recibir este aviso electrónicamente, todavía tiene derecho a una copia impresa de este aviso. Para obtener una copia impresa de este aviso, comuníquese con el Funcionario de Privacidad. También puede obtener una copia en el sitio web del DHS, en la página de inicio de la Oficina del Asesor General: https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel

MODIFICACIONES A ESTE AVISO:

El DHS se reserva el derecho a modificar este aviso y a plicar el nuevo aviso a la Información Médica que ya se obtuvo y a la información que se reciba en el futuro. El DHS publicará una copia del aviso vigente en nuestras oficinas y en el sitio web https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel. Este aviso incluirá la fecha de entrada en vigencia la esquina superior derecha de la primera página.

RECLAMOS:

Si tiene alguna duda con respecto a este aviso, contáctese:

Departamento de Servicios Humanos de Georgia
Funcionario de privacidad
2 Peachtree Street NW, 29th Floor
Atlanta, GA 30303-3142
HIPAADHS@dhs.ga.gov

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

También puede presentar un reclamo al secretario del Departamento de Salud y Servicios Humanos, Oficina de Derechos Civiles (OCR). Si desea obtener más información sobre los requisitos de privacidad de la Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPAA), las transacciones electrónicas de conformidad con la HIPAA, y las normas de códigos y las reglas de seguridad de HIPAA propuestas, visite el sitio web del Departamento de Salud y Servicios Humanos de los Estados Unidos en https://www.hhs.gov/hipaa/index.html.

Si tiene dudas sobre su salud o sus servicios de atención médica, debe contactarse con su proveedor de atención médica (médico, farmacia, hospital u otro proveedor).

[SIGUE PÁGINA DE FIRMAS]

PÁGINA DE FIRMAS

Si desea acusar recibo de este Aviso de prácticas de privacidad de HIPAA del DHS, firme a continuación, y envíe esta página a la dirección que se encuentra a continuación:

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

_____ _____

Firma Fecha

_____

Nombre en letra imp

Dirección de envío:

[Ingresar la dirección local aquí]

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

This document is for informational purposes, only for applicants, who apply for PE WHM with Qualified Providers/Qualified Hospitals. It explains to them the DFCS for WHM and what to expect if their application is approved for this program.

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Quick Guide on Women's Health Medicaid

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

- You have been approved for Women's Health Presumptive Eligibility (PE) that provides eligibility from the date of your application approval until the end of the second month. Your application is being sent to the Department of Family and Children Services (DFCS) to determine the eligibility of ongoing coverage for Women's Health.

- If you remain eligible for Women's Health, you will be assigned an Economic Support Specialist through the Georgia Gateway system. Your caseworker's information will be on your notice. You may contact the DFCS call center at 1-877-423-4746 concerning your case.

- You will receive a letter in the mail letting you know whether or not your application is approved or denied for ongoing eligibility. If approved, you will be covered for a year. Thereafter, your eligibility will be renewed yearly if you are still in cancer treatment. You can complete your renewal at www.gateway.ga.gov. There may be other types of Medical Assistance that may cover you after that point.

- As soon as you are eligible for Medicaid, you will be auto-enrolled in a Care Management Organization (CMO). You will receive a welcome package from the CMO selected. If you prefer a different CMO than the one selected, you have 90 days to change to a different CMO by contacting Georgia Families at 1-888-423-6765 (1-888-GA-ENROLL) or by internet at http://www.georgia-families.com.

- You must call your Economic Support Specialist within 10 days of **all** household changes; especially if your cancer treatment has ended.

- You will be eligible for Medicare the month you turn 65 years of age and therefore no longer eligible for Women's Health Medical Assistance. If you become eligible for Medicare prior to age 65, you are no longer eligible for WHM at that point. You will be reviewed for continuing eligibility however, please prepare for this change, so you are not without coverage. Any questions regarding Medicare can be answered by contacting Medicare at 1-800-MEDICARE (1-800-633- 4227); TTY 1-877-486-2048 or www.Medicare.gov

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

Revised 09/13/2021

Information for the WHM Customer

WOMEN'S HEALTH MEDICAL ASSISTANCE (WHM)

What is the Women's Health Medical Assistance Program?

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

What you should know about the process:

- The Department of Public Health explains the temporary WHM coverage.
- Your Presumptive Eligibility (PE) application is forwarded to the Division of Family and Children Services (DFCS) to determine if you meet the criteria for ongoing Medical Assistance under WHM. Your Medical Assistance application for WHM can be terminated by DFCS if other circumstances are known to the agency that was not reported on your PE application.
- If verification of citizenship, identity, or income is required, you can submit verification online at www.gateway.ga.gov or you may mail it to DFCS WHM Team, Attn: WHM 434 West 12th Street Alma, Ga 31510. If you are not able to provide the requested proof of citizenship or identity by the deadline indicated; your Medical Assistance application for the individual may still be approved. You will have three (3) months from the date of the Medical Assistance approval notice to submit the required documents.
- Failure to cooperate with any request in a timely manner will result in your Medical Assistance being terminated. You would have to reapply for the coverage.
- You can request Retroactive Medical Assistance that will allow (up to 3 months) prior to the date of application. Income verification is required on each prior month requested. To be approved, you must meet the following criteria:
    - Income must be under 200% of the Federal Poverty Level
    - Your diagnosis must be in the three months prior to the month of your Medical Assistance application
- After your approval for Presumptive Eligibility (PE) WHM, you are auto assigned into a Care Management Organization (CMO). You will receive a welcome package from the CMO selected. If you prefer a different CMO than the one selected, you have 90 days to change to a different CMO by contacting Georgia Families at (1-888-GA-ENROLL) or by internet at http://www.georgia-families.com.

Renewal Process Overview:

- Your case will be renewed every year in the month of your application. A renewal application e must be completed either online or a paper application that can be uploaded into the Georgia Gateway or mail to the DFCS WHM Team at 434 West 12th St Alma, Ga 31510.
- A renewal reminder letter is mailed to the last reported address.
- You must verify that you are currently in treatment by returning a completed Physician's Statement of Treatment form signed by an authorized professional. All renewals can be submitted through www.gateway.ga.gov.
- Proof of Income is required at renewal to determine your continual eligibility under Medical Assistance. Income must be under 200% of the Federal Poverty Level.
- The month after you turn 65, you are no longer eligible for this type of Medicaid Assistance even if you are still receiving treatment.

What is your responsibility?

- Report any change within 10 days of the change by going online at www.gateway.ga.gov or by contacting the Office of Family Independence (OFI) call center at 877-423-4746. Reported changes include, but are not limited to:
    - If your treatment ends for breast or cervical cancer
    - If you had a gender and/or name change
    - You move and/or your contact information changes
    - Report any household income changes
    - If you receive other health insurance or you become SSI and/or Medicare eligible

Helpful Internet Sites:

http://www.georgiacancer.org/treat-aid.php (404)-463-5111 http://www.cancer.org/docroot/home/index.asp *(1-800-227-2345)*

Revised 09/02/2021

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor — Caylee Noggle, Commissioner

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

PRESUMPTIVE ELIGIBILITY MANUAL UPDATES

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

TODAY'S DATE: _____

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

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

Name ☐ _____

Address ☐ _____

Social Security Number ☐ ___ - ___ - ____ **Date of Birth** ☐ ___ / ___ / ____ **(MM/DD/YEAR)**

Expected Birth Date of Fetus(es) ☐ ___ / ___ / ____ **(MM/DD/YEAR)**

Number of Births ☐ _____

Terminate P4HB ☐

Add PE to GAMMIS ☐ **PE 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/U.S. National ☐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

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Revised 8/30/21

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Caylee Noggle, Commissioner

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

Supplemental Security Income (SSI) Pregnant Women Update

Email to DCH: pecorrections@dch.ga.gov

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

CONTACT INFORMATION: Please print clearly

Name of person completing this form:	
Agency Name:	
Direct phone number:	
Date emailed:	

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Revised 7/28/21

Statement of Treatment Form DMA 632WQP

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

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

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

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor — Caylee Noggle, Commissioner

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

Physician Statement of Treatment for Breast and/or Cervical Cancer

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

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

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

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

Must Specify Treatment:

_____

_____

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

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

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

_____ Title

_____ Date (Good only for 30 days)

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

Address: _____

Phone #: _____ Fax #: _____

The form may be submitted to www.gateway.ga.gov or womenshealth@dhs.ga.gov.

Caseworker Name		Email Address	
Telephone Number		Fax	912-377-1134
Mailing Address	RSM Group, Attn: WHM, 434 W. 12th Street, Alma, GA 31510		

Revised 7/15/2021

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor — Caylee Noggle, Commissioner

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

Physician Statement of Treatment for Breast and/or Cervical Cancer

INSTRUCTIONS

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

I. **Demographics**:
   a. Must complete Patient Full Name
   b. Patient Date of Birth (DOB)
   c. Patient Social Security Number (SSN) if available

II. **Diagnosis and Certification of Treatment**:
   a. Must fill in the Diagnosis Date, the date cannot be left blank
   b. Diagnosis of Breast Cancer must be checked by indicating which type of cancer: InSitu, Invasive Cancer or Triple Negative.
   c. Diagnosis of Cervical Cancer must be checked by indicating which type of cancer: CIN II, CIN III or Invasive Cancer

III. **Provider's Information**:
   a. A physician or authorized licensed medical professional must certify if patient is in **ACTIVE** treatment for Breast and/or Cervical Cancer, explanation of what treatment or list the Medication treatment the patient is taking for treatment such as, (Tamoxifen, Arimedex, Anastrozole, Raloxifene, Toremifene, Fulestrant, Letrozole and Exemestane etc.) is considered as being in treatment for cancer.
   b. You must specify the treatment the patient is receiving.
   c. If the patient is **NOT** in active treatment the box should be checked only and no explanation is needed.
   d. The physician or the authorized licensed medical professional signature must be in its original format certifying this information is true and accurate. A stamped signature is not acceptable.
   e. The person completing this form must complete the name of the clinic, address, phone number and fax number.

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

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

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 three 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 three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.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 three CMOs are State-wide.**

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

- Amerigroup Community Care
- CareSource

- Peach State Health Plan

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
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/Georgia Medicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.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 GAINWELL TECHNOLOGIES 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. GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES 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 recredentialed multiple times.

The CVO's one-source application process:

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

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

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES 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
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 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)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: 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 State website, or the Peach State provider manual.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
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 moral or religious objections • PCP moves, retires, etc.	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 warrant an immediate PCP change.

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

Amerigroup Community Care	CareSource	Peach State Health Plan
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following 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
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.pshpgeorgia.com

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 #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES 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
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

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?

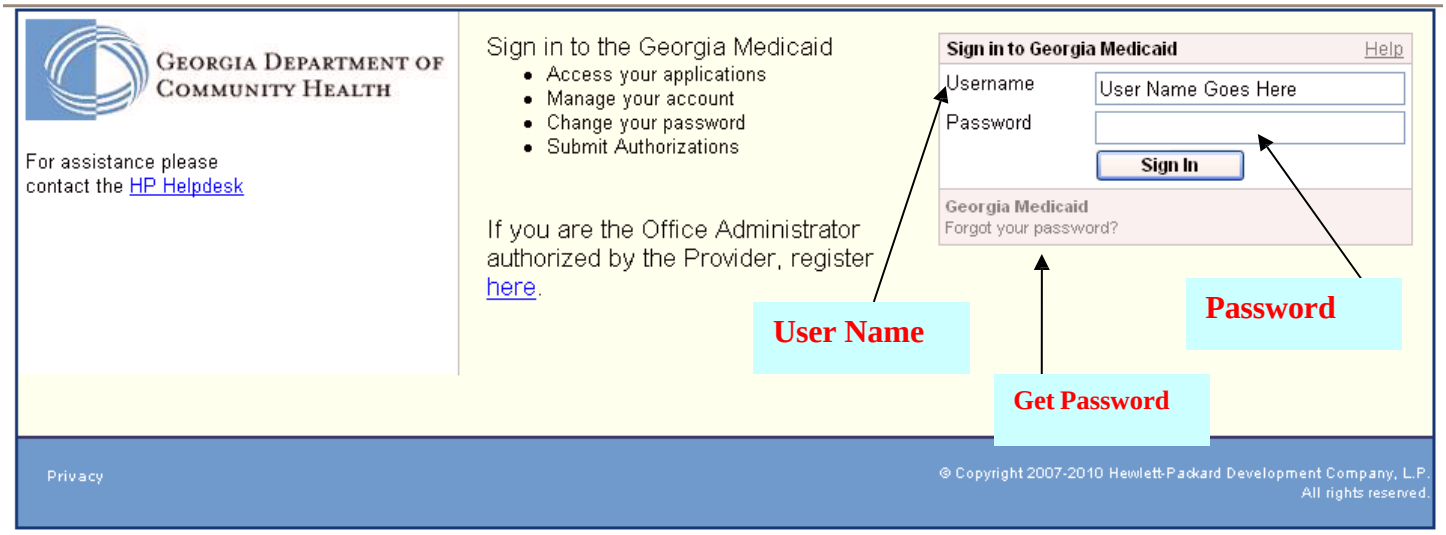
No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

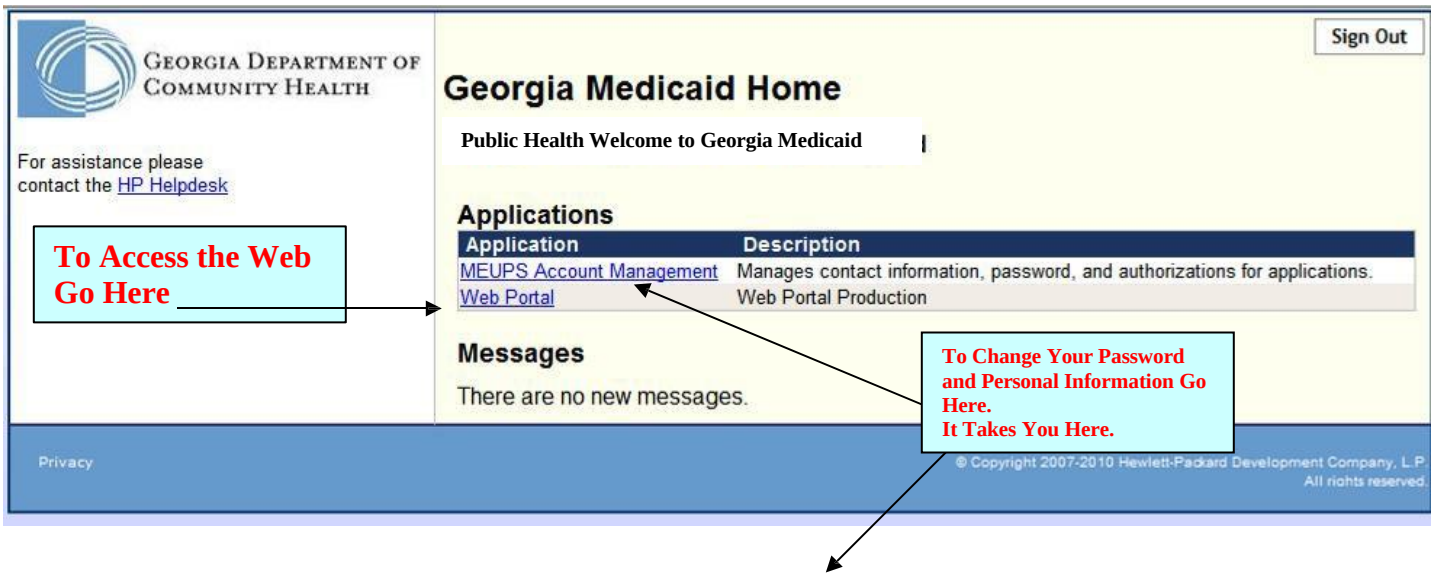
Who to call to request a PA:

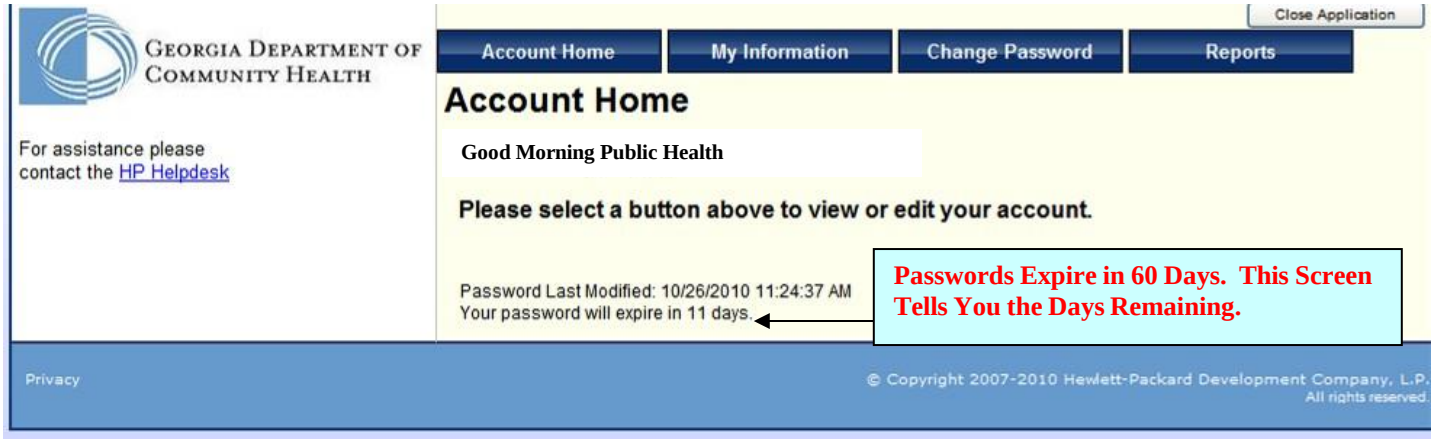
Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX G
GAMMIS

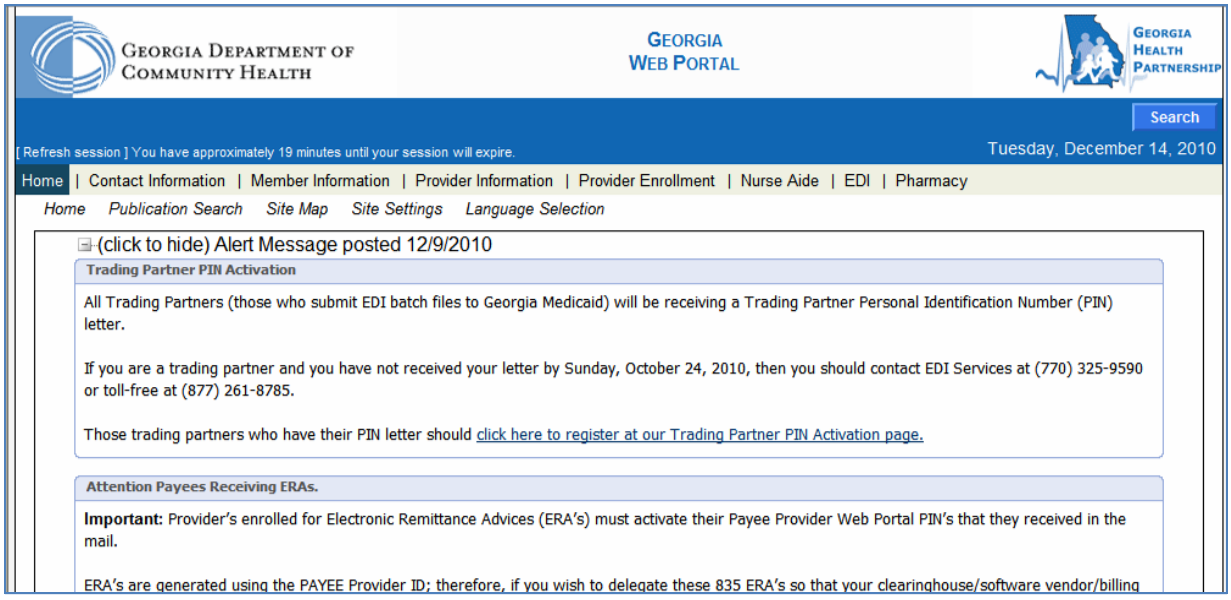
Sign on to GAMMIS:

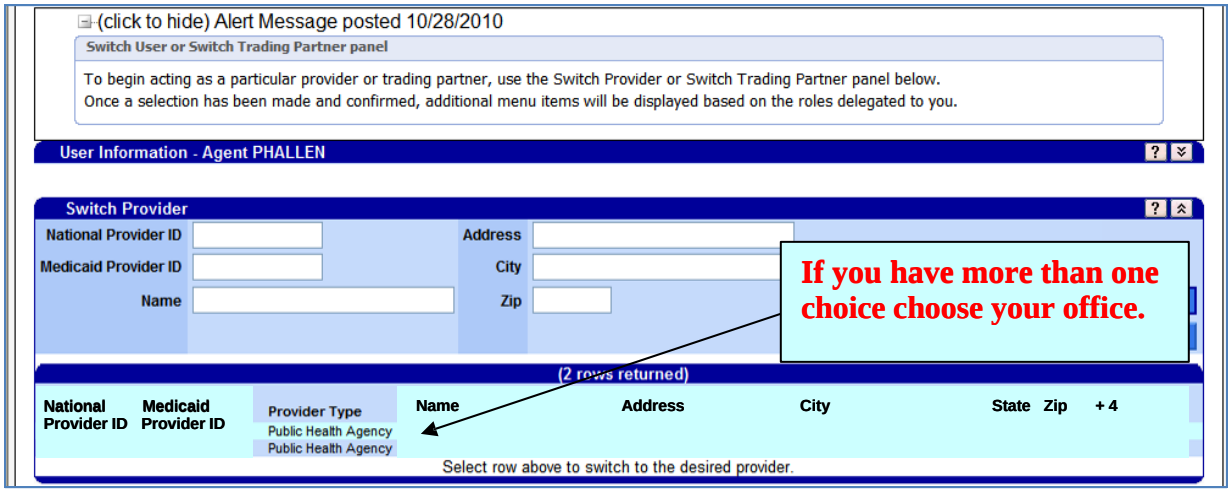




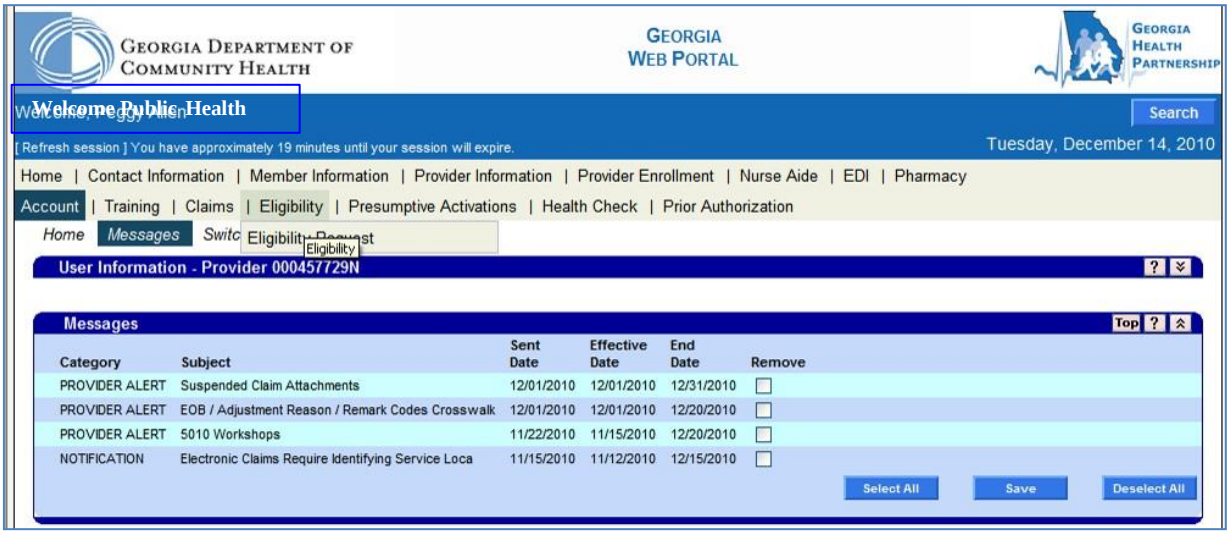


Going to the Web:



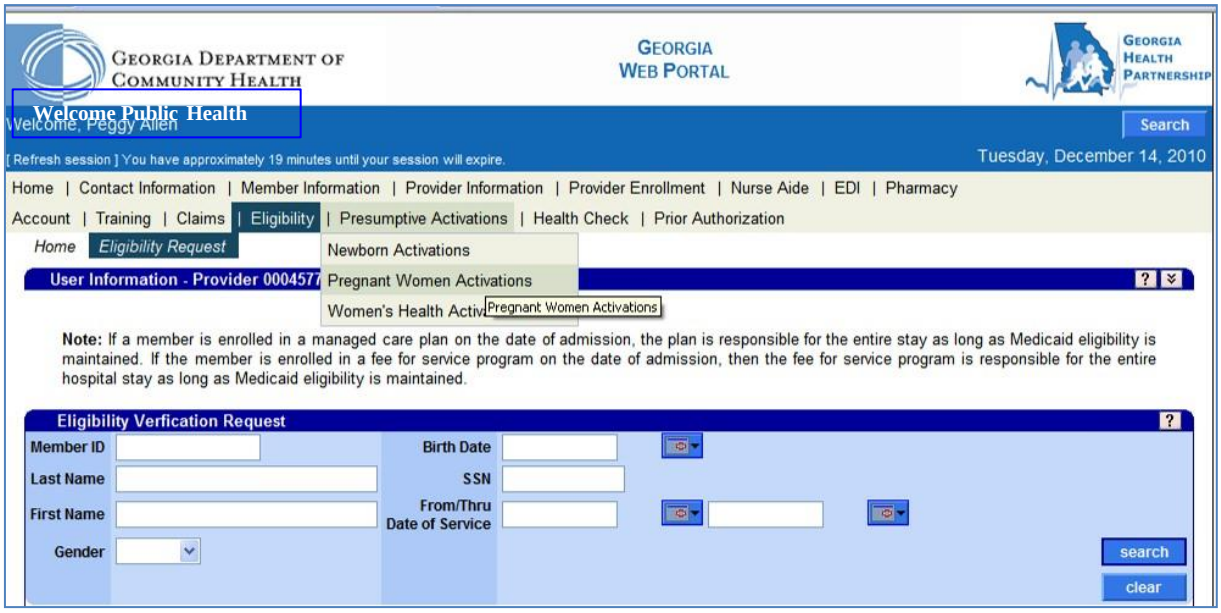


Messages:

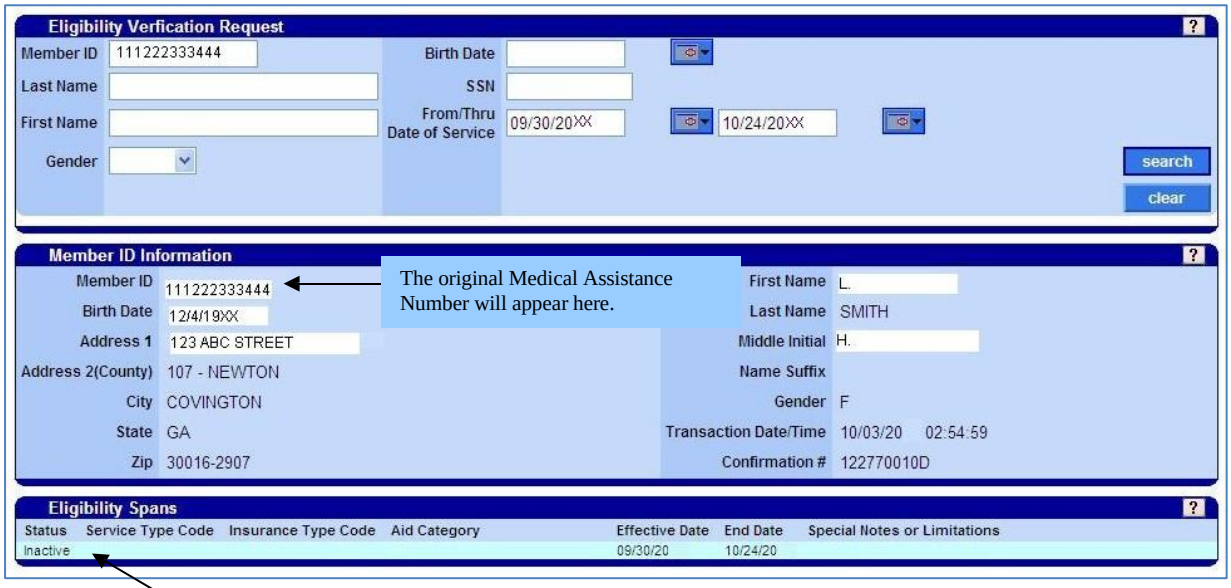


Screening on the web portal:

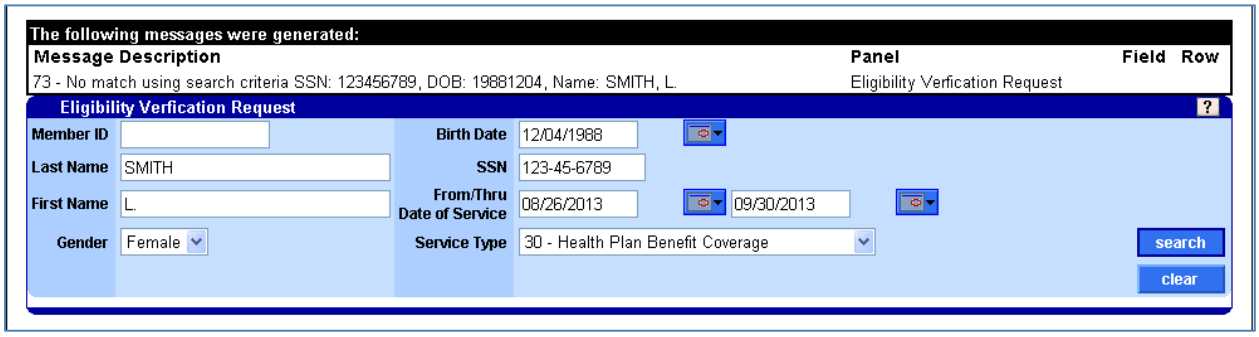
Always screen on the web first to make sure the applicant is not already active on Medicaid.



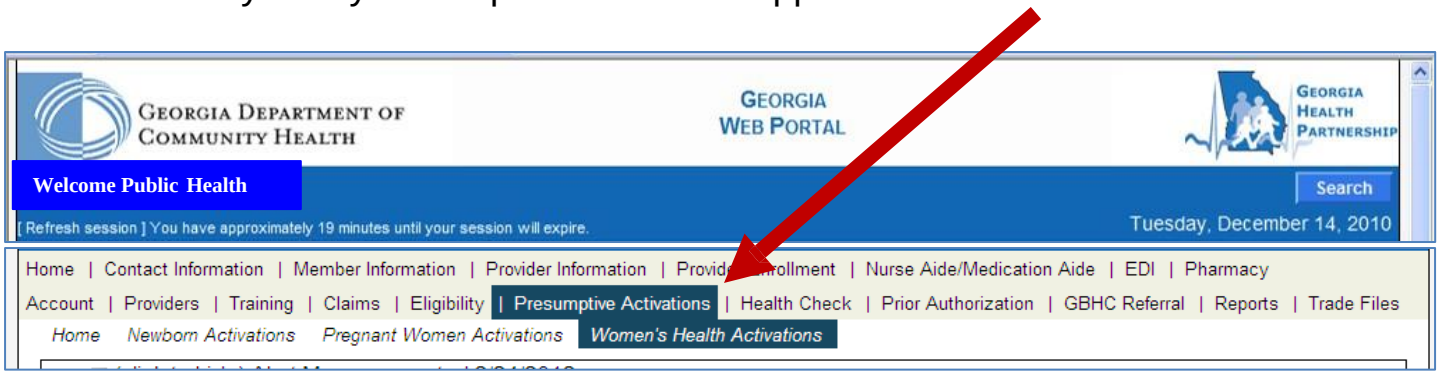
If the applicant was ever known to the system you will see her as inactive at the bottom of the screen.



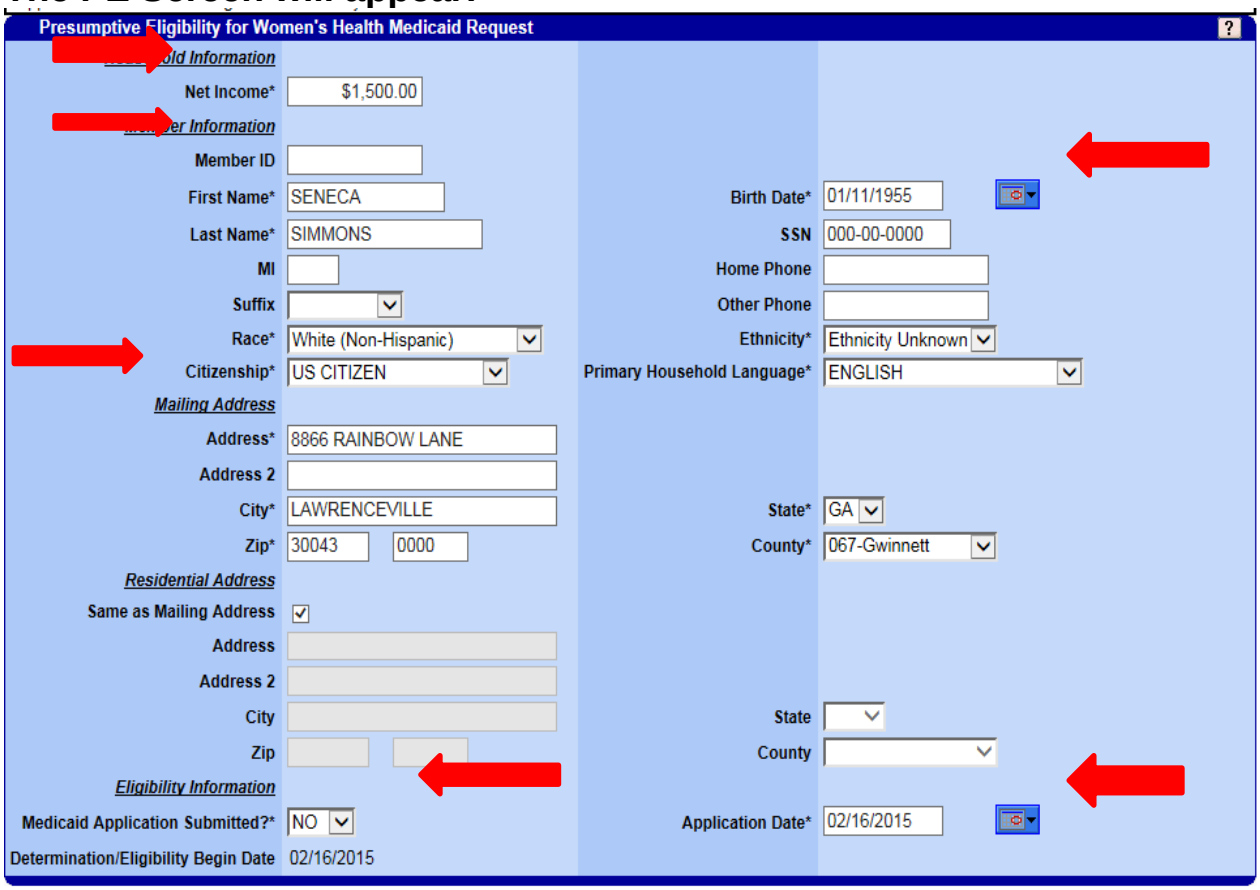
If the applicant has never had Medical Assistance this screen will not appear.



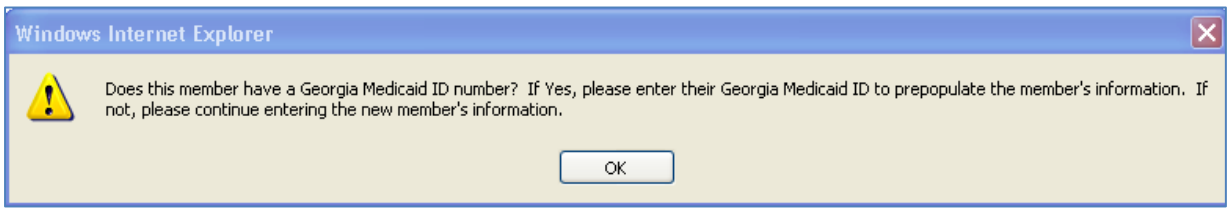
If your applicant does not have active Medical Assistance nor has ever been known to the system you can process the PE application online. Use the PE tab:



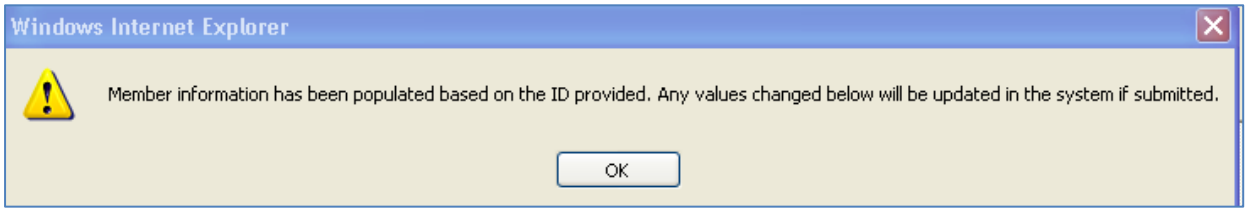
The PE Screen will appear:



Enter the member's original ID number to auto-populate the fields on this panel. You will be prompted to do so with this alert message:

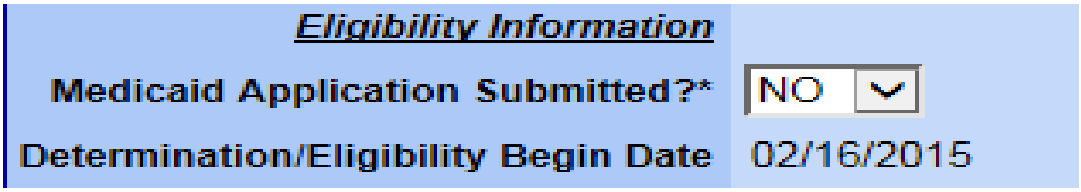


All information can be changed except the First Name, Date of Birth (DOB) and Social Security Number (SSN). If this information needs to be corrected use the current PE Manual Updates procedure after you enter the PE on the Web.
Once you enter the Member ID number and the submit button you will receive this alert message:

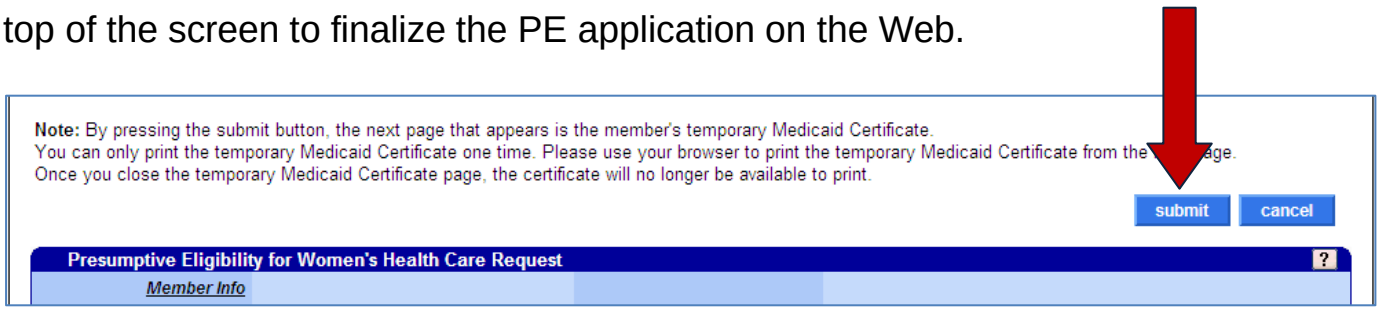


The applicant's last known information in GAMMIS will auto-populate.

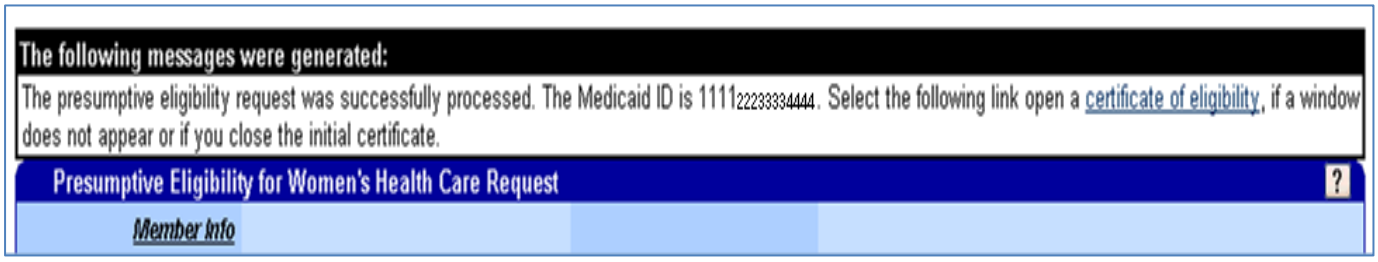
* The Determination/Eligibility Begin Date field will pre-populate with today's date and cannot be modified.



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



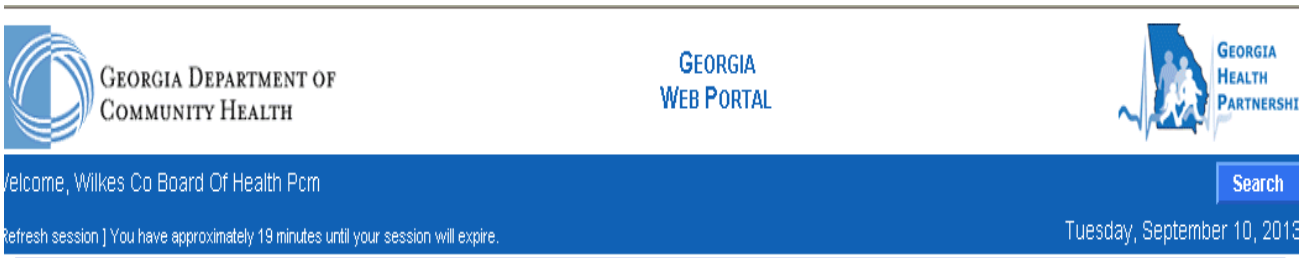
The presumptive eligibility request was successfully processed message will appear:



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

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





Temporary Member Identification Card

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

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

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

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

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

Rx BIN Number: 001553

Eligibility Verfication Request

From/Thru Date of Service 08/01/2013 09/30/2013

Service Type 30 - Health Plan Benefit Coverage

Eligibility Spans

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

Appendix I- INCOME

SOURCE OF INCOME	DESCRIPTION
ADOPTION ASSISTANCE	**Unearned** - Money received for the adoption of certain children. **Exclude**
ADVANCE (not a prepayment of wages or salary)	**Unearned** - Money for future expenses that does not represent a gain to the budget unit. **Exclude**
AGENT ORANGE PAYMENTS	**Unearned** - Payments made to Vietnam veterans exposed to Agent Orange Defoliant and to their surviving spouse and children. **Exclude**
ALASKA NATIVE CLAIM	**Unearned** - Payments made under the Alaska Native Claims Settlement Act. **Exclude**
ALIMONY/SPOUSE SUPPORT	**Unearned** – A court-ordered payment from an estranged spouse or former spouse to the other spouse. **Include**
BLOOD, THE SALE OF	**Earned** – Money received from the sale of blood including blood products. **Include**
(TEMPORARY) CENSUS BUREAU EARNINGS	**Earned** - Remuneration paid for temporary employment related to census activities. **Exclude**
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATIONS NOT STATE OR FEDERALLY FUNDED	**Unearned** - Contribution to the budget unit. Exclude all that are not from the state or federally funded agencies.
CHILD'S EARNINGS	**Earned** - Income earned by a child under age 19. **Exclude**
CHILD SUPPORT	**Unearned** – Income received for the support of the child (ren) from the non-custodial parent of the child. Child support paid for a child by a non-custodial parent is always income to the child and never to a parent/ relative/ guardian. **Include**
COMMISSION	**Earned** – A payment, usually a set fee or percentage, made to an employee for his/her service in facilitating a transaction such as buying or selling goods. A commission may be paid in lieu of or in addition to a regular salary. **Include**
CONTRIBUTION, GIFT, PRIZE, AWARD	**Unearned** – Money is given to the AU as a gift from individuals or organizations. **Include**
DISASTER RELIEF	**Unearned** - Governmental payments for the restoration of a home damaged by a disaster. **Exclude**

DIVERTED INCOME	**Unearned** – Money deducted or diverted by a court order to a third party. Exclude Unearned – Money that is legally obligated to an AU member by a court order but is diverted at the option of the AU member to a third party. **Include**
EARNED INCOME TAX CREDIT	**Unearned** - IRS credit received as advanced payments as part of a regular paycheck or received a part of an income tax refund (EITC). **Exclude**
EDUCATIONAL GRANT, LOAN, SCHOLARSHIP	**Unearned** - Payments for educational assistance of a budget unit member. **Exclude**
ENERGY ASSISTANCE	Unearned - Payment or allowance received under federal, state, or local laws for utility expenses. Exclude
FEDERAL PROGRAMS	**Unearned** • Federal Housing Assistance • Food Stamps • Food Programs with federal involvement for Older Americans • Refugee Cash Assistance, Cuban and Haitian • Entrant Cash Assistance and federally reimbursed general assistance payments to refugees • Refugee reception and placement grants and refugee matching grants • Relocation Assistance **Exclude**
FOSTER CARE PAYMENTS	**Unearned** – (IV- B) per diem payments received by the foster parents to provide for the needs of the foster child and foster family. **Exclude** (IV-E) per diem payment received to provide for the needs of the foster child. Exclude as income to the foster child.
GARNISHMENT	**Earned/Unearned** – A set amount of wages or monies withheld by an employer/entity to pay a debt owed to a third party. **Include**
GENERAL ASSISTANCE	**Unearned** – payments received by the Applicant/Member from county funds administered by DFCS. **Exclude** **Unearned** - GA paid directly to the provider if paid for housing expenses including GA paid for transitional housing for the homeless and if paid for energy or utilities. **Exclude**

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

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

WAGES (SALARY)	**Earned** – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis. Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee's share of FICA when paid by the employer. **Include**
WORKER'S COMPENSATION	**Unearned** – payments awarded to injured employees or to their survivors. Exclude any portion designated for medical, legal, or related expenses paid or deducted and not controlled by the applicant in connection with the claim. **Include**
WORK STUDY PROGRAM	**Earned** – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money. **Exclude**

CONVERSION CHART

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

2021 FEDERAL POVERTY GUIDELINES

FAMILY SIZE	MONTHLY INCOME LIMIT
1	**$2147**
2	**$2904**
3	**$3660**
4	**$4417**
5	**$5174**
6	**$5930**
7	**$6687**
8	**$7444**

EACH ADDITIONAL PERSON:
ADD $757

Effective for Determinations Made on or After March 1, 2021

APPENDIX M MEMO

MEMO Date	Title
11/16/10	GAMMIS
12/07/10	Planning for Healthy Babies (P4HB)
01/20/11	Presumptive Eligibility and GAMMIS
03/09/12	Updated PE Changes/Corrections Procedures
05/31/12	System Fix Completion for PE and active P4HB
03/31/13	Increase in Income Levels for Presumptive Eligibility Medicaid
04/15/13	SSI Pregnant Woman Update
12/23/13	Affordable Care Act Changes for PE Medicaid
01/14/14	PE Medical Assistance Training
04/07/14	Presumptive Eligibility Medical Assistance Federal Poverty Levels and Forms
02/2/15	Presumptive Eligibility Medical Assistance Federal Poverty Levels
03/04/15	GAMMIS system changes for Presumptive PGW and Presumptive WHM
07/28/16	Transgender Woman
02/10/17	Notice to Member of the new Gateway system and Renewal
02/16/18	Increase in Income Levels for Presumptive Eligibility Medical Assistance
12/2016	RHA News Update – December 16, 2016 Breast Reconstructions and Prostheses after Mastectomy
2/20/2019	2020 PE Medical Assistance FPL
10/19/2019	Planning for Healthy Baby (P4HB) “Within Three Years”
2/19/2021	2021 PE Medical Assistance FPL

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

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

Presumptive Eligibility Manual

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

Forms

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

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

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

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Clyde L. Reese, III, Esq., Commissioner Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

MEMORANDUM

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

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

DATE: December 7, 2010

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

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

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

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

Family Planning Services

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

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

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

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

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

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

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

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

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

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

Inter-Pregnancy Care Services

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

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

Resource Mother Services

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

The Resource Mother services will assist these members with:

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

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

P4HB Program Requirements:

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

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

P4HB Application and Process

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

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

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

Fax: 1-888-744-2102

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

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

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

P4HB Aid Categories and New CMO Card

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

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

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

David A. Cook, Commissioner Nathan Deal, Governor

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MEMORANDUM

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

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

Date: March 9, 2012

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

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

CURRENT PROCEDURES

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

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

NEW PROCDURES

Effective immediately, but no later than 4/1/12, QP/DPH will fax required PE correction requests directly to the DCH fiscal agent, HP, using the attached coversheet. Required changes include:
Name
Address
Residential County Code
Social Security Number
Date of Birth
Duplicate ID Merge
Application Date

Additional corrections that can be made with any of the required changes listed above include:
Administrative County Code
Race
Ethnicity
Citizenship
Expected Birth Date of Fetus
Number of Births

COVERSHEET

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

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

The coversheet contains four (4) sections.

1. **Identify PE**

PRESUMPTIVE ELIGIBILITY CHANGES/CORRECTIONS

FAX TO: HP Member Enrollment **TODAY'S DATE:** _____
1-866-483-1045

UPDATE (check one): ☐ **PE PREGNANCY** Attach Form 632 ☐ **PE WHM** Attach Form 632W

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

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

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

2. **Required Changes/Corrections Needed**

Name ☐

Address ☐

Residential County Code ☐

Social Security Number ☐

Date of Birth ☐

Duplicate ID Merge: _____Original _____ Duplicate

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

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

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

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

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

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

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

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

3. Additional changes

Administrative County Code ☐

Race: ☐American Indian or Alaskan ☐Asian ☐Black ☐Caucasian

☐ Hispanic ☐Other: _____ (specify)

Ethnicity: Hispanic ☐ N/A ☐

Citizenship: ☐ U.S. Citizen ☐ Qualified Immigrant ☐ Illegal Immigrant

☐ Other: _____ (specify)

Expected Birth Date of Fetus ☐

Number of Births ☐

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

4. Contact Information

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

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

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

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

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

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

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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

David A. Cook, Commissioner

Nathan Deal, Governor

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MEMORANDUM

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

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

DATE: January 31, 2013

SUBJECT: Increase in Income Levels for Presumptive Eligibility (PE) Medicaid

The poverty level income limits used to determine Presumptive Eligibility Medicaid have changed. Income limits are based on the federal poverty guidelines that are revised and published annually. These new income limits should be used for all Presumptive Eligibility determinations completed by the Department of Public Health, beginning February 1, 2013.

Federal Poverty Guidelines

Family Size	Monthly Income Limit
1	$ 1916
2	$ 2586
3	$ 3256
4	$ 3926
5	$ 4596
6	$ 5266
7	$ 5936
8	$ 6606

EACH ADDITIONAL PERSON ADD: $670

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

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

GEORGIA DEPARTMENT
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April 15, 2013

MEMORANDUM

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

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

SUBJECT: GAMMIS update for SSI Pregnant Members

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

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

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

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

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

Attachment:

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

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MEMORANDUM

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

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

DATE: January 31, 2013

SUBJECT: Increase in Income Levels for Presumptive Eligibility (PE) Medicaid

The poverty level income limits used to determine Presumptive Eligibility Medicaid have changed. Income limits are based on the federal poverty guidelines that are revised and published annually. These new income limits should be used for all Presumptive Eligibility determinations completed by the Department of Public Health, beginning February 1, 2013.

Federal Poverty Guidelines

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7	$ 5936
8	$ 6606

EACH ADDITIONAL PERSON ADD: $670

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

cc: Jon Anderson, Deputy Chief, Member Services & Policy
Jonathan Duttweiler, DHS/DFCS Medicaid Policy Unit Manager
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Cathy Broom, Program Consultant, Division of Public Health
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Federally Qualified Health Centers/Rural Health Centers

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Clyde L. Reese III, Esq., Commissioner

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December 23, 2013

MEMORANDUM

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

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

RE: Affordable Care Act Changes for Presumptive Eligibility Medicaid

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

FEDERAL POVERTY LEVEL (FPL)

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

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

FORMS

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

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

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

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

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

ACA CHANGE FOR PE MEDICAID

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

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

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

PE TRAINING

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

PREGNANCY CORRECTIONS

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

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

QUALIFIED HOSPITALS

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

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

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

ATTACHMENTS

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

GEORGIA DEPARTMENT
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January 14, 2014

MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Training

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

PE PREGNANCY MEDICAID

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

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

PE WOMEN'S HEALTH MEDICAID (WHM)

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

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

PE HOSPITAL MEDICAID TRAINING

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

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

FORMS

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

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

ATTACHMENT

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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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

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

April 7, 2014

MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels and Forms

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

FEDERAL POVERTY LEVEL (FPL)

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

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

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

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

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

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

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

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

FORMS

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

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

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

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

THIRD PARTY LIABILITY (TPL)

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

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

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

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

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

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

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

PE PREGNANCY CORRECTIONS

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

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

PE PREGNANT WOMEN MEDICAID CLOSURES

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

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

ATTACHMENTS

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

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Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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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 Group	220% FPL	5% Deduction	220% 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

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

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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
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

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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 2016

DATE: February 19, 2016

The purpose of this memorandum is to inform Qualified Providers (QP) and Qualified Hospitals (QH) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2015. The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2015 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in processing presumptive eligibility effective April 1, 2016.

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

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

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

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

Budget Group	200% FPL
1	1980
2	2670
3	3360
4	4050
5	4740
6	5430
7	6122
8	6816
9	7510
10	8202
11	8896
12	9590

Add $694 to the net income limit for any additional individual(s) added.

Please distribute to all State Office Staff, Supervisors, and members of the QP team that process the PE Pregnant Women Medicaid and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact Lorraine Russell, Healthcare Program Consultant 3, at 404-651-9978.

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

Breast and Cervical Cancer Program

Clinical Services Section

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

Date Created: 2016 Approved by: BCCP Administration Leadership

Date Revised: _____

POLICY

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

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

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MEMORANDUM

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

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

DATE: July 18, 2016

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

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

POLICY:

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

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

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

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

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

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

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

RHA News Update – December 16, 2016

HHS News

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

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Nathan Deal, Governor

Frank W. Berry, Commissioner

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

February 10, 2017

Dear Beneficiary,

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

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

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

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

MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2017

DATE: February 15, 2017

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

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

For each additional person over Budget Group size 12:
Add $50 (Parent/Caretaker with Children under 19)
Add $462 (133% FPL)
Add $517 (149% FPL)
Add $711 (205% FPL)
Add $763 (220% FPL)

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

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

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

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

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

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Frank W. Berry, Commissioner

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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

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 McKever, 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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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

MEMORANDUM

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

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

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2019

DATE: February 20, 2019

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

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

For each additional person over Budget Group size 12:
Add $19 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $490 (133% FPL)
Add $549 (149% FPL)
Add $755 (205% FPL)
Add $811 (220% FPL)

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

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

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

Please distribute to all Hospital Staff, Supervisors and members of the QH team that process PE Parent/Caretaker with Children under age 19, PE Children under age 19, PE Pregnant Women and/or PE Women's Health Medical Assistance determinations. If you have any questions or need additional information, please contact Kunita 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, Right from the Start Medical Assistance Group Director
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Melanee Payne, Interim Quality Control Program Director
Stefanie Ashlaw, Director, PeachCare for Kids®
Karen Salter, Myers and Stauffer

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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager AW
DCH Policy, Compliance and Operations Office

DATE: October 11, 2019

SUBJECT: Planning for Healthy Babies (P4HB) "Within Three Years"

The Center for Medicare and Medicaid Services (CMS) recently approved a 10-year extension of the Planning for Healthy Babies (P4HB) 1115 waiver. The approval included a change to the Special Terms and Conditions for P4HB Inter-Pregnancy Care (IPC) 180 and Resource Mother (RM) 182-183. The change is effective January 1, 2020.

Currently, an applicant who delivers a Very Low Birth Weight (VLBW) Baby on or after January 1, 2011, she is potentially eligible for IPC 180 or RM 182-183 Services. Effective January 1, 2020 an applicant must have delivered a VLBW Baby "Within Three Years" of the application date. If the baby was born beyond three years of the application date, the applicant will not meet the qualifications for P4HB IPC 180 or RM 182-183 Services.

Please add this policy change to the Planning for Healthy Babies section in ODIS Section 2186. Also, issue a numbered bulletin to expedite dissemination of this information to field staff and update Georgia Gateway to reflect this change. If you have any questions, please contact Lorraine Russell at lrussell2@dch.ga.gov or 404-651-9978 or Anika Washington at awashington1@dch.ga.gov or 404-657-7262.

Cc: Lynette Rhodes, Executive Director, Medical Assistance Plan
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Jonathan Duttweiler, Deputy Executive Director, Eligibility and Enrollment Office
Yvonne Greene, Policy Administration Director
Mandy Corlee, Right from the Start Medical Assistance Group, Interim Director
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Melanee Payne, Medicaid Eligibility Quality Control Manager
Stefanie Ashlaw, PeachCare for Kids® Director
Karen Salter, Myers and Stauffer

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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

SUBJECT: **2020 MAGI Federal Poverty Level Guidelines**

DATE: February 6, 2020

The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2020 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in all MAGI based eligibility case actions, effective on or after March 1, 2020 for the following Medical Assistance MAGI groups:

Pregnant Women
Children under age 19
Parent/Caretaker with Child(ren)
Peachcare for Kids®

Planning for Healthy Babies (P4HB) remains at 211% of the Federal Poverty Level and Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level. Please use this income limit for these programs' effective March 1, 2020.

	Children 6-19	Children 1-5	Children 0-1/TMA	WHM	P4HB	PGW	PCK
Family Size	133%	149%	205%	200%	211%	220%	247%
1	1,415.00	1,585.00	2,180.00	2,127.00	2,244.00	2,340.00	2,627.00
2	1,911.00	2,141.00	2,946.00	2,874.00	3,032.00	3,161.00	3,549.00
3	2,408.00	2,697.00	3,711.00	3,620.00	3,820.00	3,982.00	4,471.00
4	2,904.00	3,254.00	4,476.00	4,367.00	4,607.00	4,804.00	5,393.00
5	3,401.00	3,810.00	5,242.00	5,114.00	5,395.00	5,625.00	6,315.00
6	3,897.00	4,366.00	6,007.00	5,860.00	6,183.00	6,446.00	7,238.00
7	4,394.00	4,922.00	6,772.00	6,607.00	6,971.00	7,268.00	8,160.00
8	4,890.00	5,479.00	7,538.00	7,354.00	7,758.00	8,089.00	9,082.00
9	5,387.00	6,035.00	8,303.00	8,100.00	8,546.00	8,910.00	10,004.00
10	5,884.00	6,591.00	9,068.00	8,847.00	9,334.00	9,732.00	10,926.00
11	6,380.00	7,148.00	9,834.00	9,594.00	10,121.00	10,553.00	11,848.00
12	6,877.00	7,704.00	10,599.00	10,340.00	10,909.00	11,374.00	12,770.00

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MEMORANDUM

TO: Diane Durrence, Chief Nurse, Director of Women's Health
Department of Public Health

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2021

DATE: February 19, 2021

The purpose of this memorandum is to inform Qualified Providers (QP) of the 2021 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) 2021 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, 2021.

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	73	3,194
3	92	4,026
4	111	4,859
5	130	5,691
6	149	6,523
7	168	7,356
8	187	8,188
9	205	9,020
10	224	9,853
11	243	10,685
12	262	11,517

For each additional person over Budget Group size 12:
Add $19 (5% Deduction)
Add $833 (220% FPL)

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

Budget Group	200% WHM
1	2,147
2	2,904
3	3,660
4	4,417
5	5,174
6	5,930
7	6,687
8	7,444
9	8,200
10	8,957
11	9,714
12	10,470

For each additional person over Budget Group size 12 add $757

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: Lynnette Rhodes, Executive Director, Medical Assistance Plans
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Catherine Ivey, Deputy Executive Director, Service Delivery and Administration
Yvonne Greene, Director, Policy Administration
Stefanie Ashlaw, Director, PeachCare for Kids®
Melonie Wilson, Director, Regulatory Services and Compliance
Lynda Chapman, Attorney and Policy Manager
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Janice Boyd, Women's Health Program Manager, Department of Public Health
Karen Salter, Myers and Stauffer

Appendix P –Planning for Healthy Babies
P4HB Education Fliers and Application in English and available in Spanish







DO YOU NEED ACCESS TO FREE BIRTH CONTROL?

WHAT IS PLANNING FOR HEALTHY BABIES (P4HB)?

Planning for Healthy Babies provides no-cost family planning services to eligible Georgia residents. The goal of P4HB is to help women be healthy and plan ahead in order to have healthy babies when they are ready to start their families! P4HB members get family planning, interpregnancy care and/or Resource Mother outreach services.

WHAT IS COVERED?

- Family planning initial or annual exams
- Follow up family planning visits
- Pap smears and pelvic exams
- Birth control and multivitamins with folic acid
- Patient education and counseling
- Select immunizations for participants aged 18-20
- Counseling and referrals to social services

WHAT ARE THE ELIGIBILITY REQUIREMENTS?

- Uninsured individuals ages 18-44
- Georgia state resident
- Family income at or below 211 percent of the Federal poverty level
- Ability to become pregnant
- Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP)

PLANNING FOR HEALTHY BABIES (P4HB)

Be Smart. Plan Before You Start!

HOW DO I APPLY?

You can apply online at: gateway.ga.gov

If you are unable to apply online, you can pick up a physical application at your local:

- Public Health Department
- Division of Family and Children Services (DFCS) Office

Completed physical applications and required documentation should be faxed (912-632-0389) or mailed to:

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



WHERE CAN I GO FOR MORE INFORMATION?

1-877-427-3224 **https://medicaid.georgia.gov/planning-healthy-babies**

PLANNING FOR HEALTHY BABIES (P4HB)

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Application for Health Coverage & Help Paying Costs

Form Approved
OMB No. 0938-1191

THINGS TO

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from **Medical Assistance.**

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

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

Apply faster online

Apply faster online at gateway.ga.gov.

What you may need to apply

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

Why do we ask for this

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

What happens next?

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

Get help with this application

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

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

Form 94a (Rev. 9/17)

STEP 1 Tell us about yourself.

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

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

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

DO Include:

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

You DON'T have to include:

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

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

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

NEED HELP WITH YOUR APPLICATION? Visit gateway.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**.

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.)**

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

NEED HELP WITH YOUR APPLICATION? Visit 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**.

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 getcoverva.org or call us at **1-877-423-4746.** Para obtener una copia de este formulario en Español, llame **1-877-423-4746.** If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135.**

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.)**

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

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

NEED HELP WITH YOUR APPLICATION? Visit getcoverage.ma.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**.

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? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ 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**.

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.

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.**

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit gateway.ga.gov or call **1-877-423-4746** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by calling the Georgia Department of Community Health, Office of Inspector General (OIG), Program Integrity Section at 404-463-7590 or toll free at 1-800-533-0686.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Agencies, DFCS and the FFM to use income data, including information from tax returns. The Health Insurance Agencies, DFCS and the FFM will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medical Assistance

- I am giving to the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical Assistance agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Agencies, DFCS and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS or the FFM that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at **1-877-423-4746**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Attachment C.

Signature	Date (mm/dd/yyyy)

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

STEP 6 Mail completed application.

Mail your signed application to the address below:

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

If you want to register to vote, you can complete a voter registration form at www.sos.ga.gov.

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

Form 94a (Rev. 9/17) **Page 8 of 8**

ATTACHMENT A

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
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

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)

Appendix R - Resources

Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

How do I get NEMT services?

If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.

All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, **you must contact the NEMT Broker serving the county you live in** to ask for Non-Emergency Medical Transportation. Contact Southeastrans for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest See the chart below to determine which broker serves your county and call the broker's telephone number for that region.

What if I have problems with a NEMT provider or broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may contact the Georgia Department of Community Health, NEMT unit.

NEMT REGIONS & COUNTIES SERVED

Region	NEMT Broker & Phone Number	Counties Served
North	**Southeastrans** *Toll free* 1-866-388-9844 *Local* 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	**Southeastrans** 404-209-4000 *Note: For Georgia Families 360°* 1-866-991-6701	Fulton, DeKalb, and Gwinnett
Central	**ModivCare** **(*formerly LogistiCare)*** *Toll free* 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	**ModivCare** **(*formerly LogistiCare)*** Toll free 1-888-224-7988 *Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities* 1-800-486-7642 Ext. 461 or 436	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	**ModivCare** **(*formerly LogistiCare)*** Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

PowerLine:

The PowerLine is a statewide toll-free telephone number that provides health care referrals.

The PowerLine is managed by Healthy Mothers, Healthy Babies Coalition of Georgia. It was established in 1984 as a means of directing pregnant women to prenatal services.

PowerLine's mission was expanded in 1989 via a contract with the Georgia Department of Community Health to assist women and children in accessing Medicaid providers and public health programs.

Today, PowerLine provides health care referrals to any Medicaid, PeachCare for Kids™ and uninsured Georgian.

PowerLine can assist both English and Spanish speaking customers in gaining accesses services.

The PowerLine maintains a database of Georgia's Medicaid and PeachCare for Kids™ accepting providers. For those not eligible for Medicaid or PeachCare for Kids™, referrals are made to healthcare providers who offer low-cost or sliding scale fee services.

To access the PowerLine, call 1-800-822-2539 or, in the metro Atlanta area, 770-451-5501 from 8:00 AM to 6:00 PM, Monday through Friday.

More information may be obtained at the following website:
http://www.hmhbga.org/index.php

You can order free material to hand out to applicants by going to:
http://www.hmhbga.org/index.php?option=com_netinvoice&action=orders&task=order&cid=2&Itemid=88

Materials Order Form

Healthy Mothers, Healthy Babies Coalition of Georgia offers FREE materials on PowerLine. Please submit your order below:



P O W E R L I N E

The Healthy Mothers, Healthy Babies PowerLine is

your source for statewide healthcare referrals and information.

Metro Atlanta 770-451-5501
Statewide 800-822-2539

Monday through Friday

8:00AM-6:00PM

PowerLine is a fast way to find exactly the care you need.
PowerLine is a free service, funded by the Division of Public Health of the Georgia Department of Community Health.

One simple call puts you in contact with:

- Medicaid Doctors
- Dental Referrals
- Low-Cost Health Resources for the Uninsured
- WIC, Children 1st, and Babies Born Healthy
- Low-Cost Prenatal Referrals
- Other Public Health Programs
- Referrals for Breastfeeding Questions
- Referrals to HIV Testing

PowerLine es una forma rápida de encontrar el cuidado que usted necesita. Una llamada le pone en contacto con:

- Referencias a Médicos
- Directorio de cuidado prenatal de bajo costo
- WIC, Children 1st, y sitios para pruebas de VIH
- Apoyo para Lactancia

How to order *Understanding Medical Assistance* booklets:

Web Access

- Go To:

https://www.mmis.georgia.gov

Member Information tab and then to the Member Notification tab.

Georgia Department of Community Health

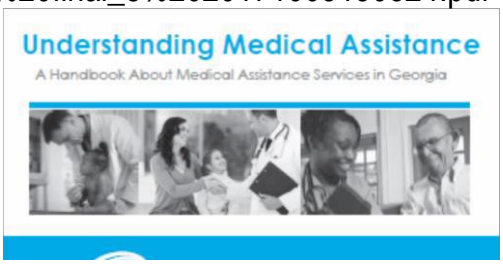
Member Information Tab:



Web Print

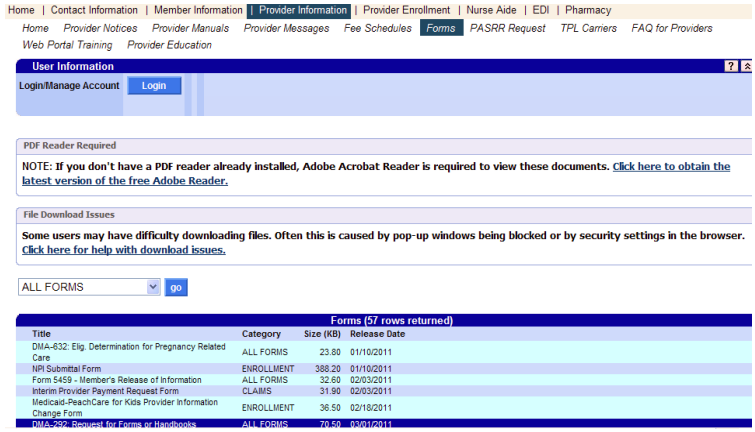
You may print the booklet from the web at the address below:

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



DMA 292 (Request for Forms)

- Download form DMA 292 from the web:



Georgia Department of Community Health

Mail DMA 292 Form

- Mail form DMA 292 to:

Gainwell Technologies
P. O. Box 105209
Tucker, GA 30085-5209

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

Georgia Department of Community Health

Ordering, Prescribing and Referring

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medical Assistance beneficiaries to be enrolled in the Georgia Medical Assistance Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b) (18) C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medical Assistance as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medical Assistance claim is associated with a provider who is not enrolled in the Georgia Medical Assistance program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by the policy will begin to deny.

For the NEW CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

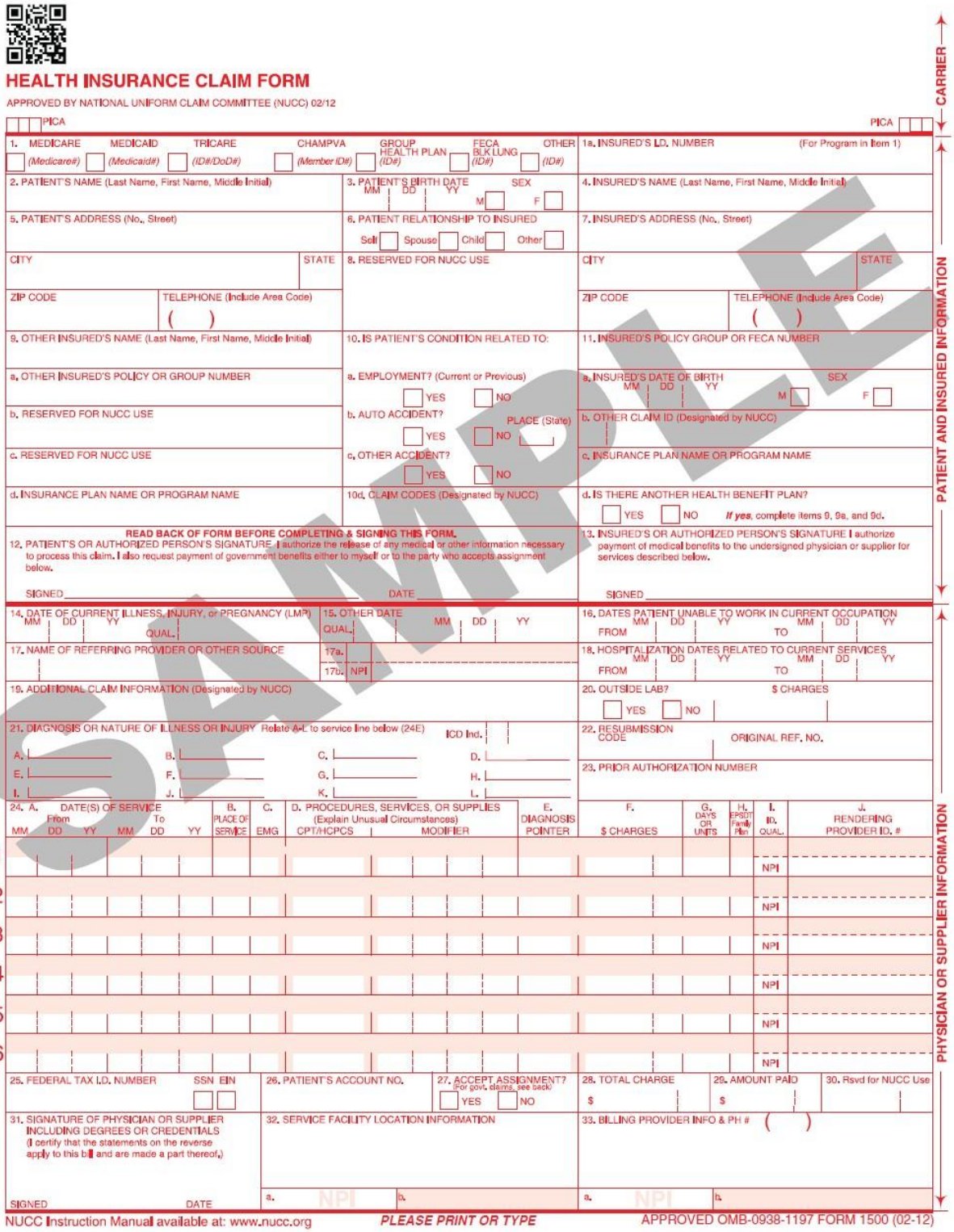
For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provides information that is now used to transmit OPR information.

NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

The following table outlines the **revised changes** to the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of the field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/HP:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added a dotted line on the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, and OR PREGNANCY (LMP)." Removed the arrow and text on the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/HP: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE the FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).

Item Number 17	Added a dotted line on the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/HP:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/HP:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after the title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before January 1, 2016.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAL ASSISTANCERESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F **FOR DCH/HP**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."