PART II

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



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE PLANS

Revised: January 1, 2023

Policy Revisions Record
Part II Policies and Procedures Manual for Hospital Presumptive Eligibility Program 2023

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
1/1/23	Footer	Updated revised date	M	
1/1/23	Table of Contents	Updated year for Section 205 title	M	
1/1/23	205	Updated training schedule	M	
1/1/23	301	Added “QDWI” with the “QI-1” step	A	
1/1/23	301	Replaced “caseworker” with “DFCS” for Women’s Health process	M	
1/1/23	502	Removed “under the U.S. Social Security system” from criteria #2c	D	
1/1/23	Appendix C	Replaced aid categories chart with full list	M	
1/1/23	Appendix R	Updated DXC Technology to Gainwell Technologies	M	

PART II- POLICIES AND PROCEDURES
AFFORDABLE CARE ACT QUALIFIED HOSPITALS
FOR PRESUMPTIVE ELIGIBILITY
PARENT/CARETAKER WITH CHILD(REN), CHILDREN UNDER THE AGE OF 19, PREGNANT WOMEN AND FORMER FOSTER CARE
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CHAPTER 100 INTRODUCTION

101 Goal of Presumptive Eligibility (PE)

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

The Department of Community Health (DCH) is committed to providing Qualified Hospitals (QH) for determining a PE for Parent/Caretaker with Child(ren), Children Under the Age of 19, Pregnant Women, and Former Foster Care with clear and practical guidelines:

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

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

**Form 632H can be used for PE Pregnant Women Medical Assistance – refer to the PE Pregnant Women manual for regulations, forms and procedures.

CHAPTER 200 OVERVIEW OF PRESUMPTIVE ELIGIBILITY

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

201 Definition and Description of Presumptive Eligibility (PE)

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

Medical Assistance coverage is available prior to a formal determination of eligibility by the Division of Family and Children Services (DFCS) office.

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

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

If the applicant is determined eligible for the program, the individual(s) receive an approval notice and temporary Medical Assistance certificate. If the eligibility continues, the individual(s) receives the plastic Medical Assistance member identification card.

The number on the card is the Medical Assistance identification number. This number will remain the same throughout the member's eligibility.

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

A Qualified Hospital is a hospital that:

(1) Participates as a Georgia Medical Assistance provider;

(2) Notifies DCH of its election to make PE determinations;
(3) Agrees to make PE determinations consistent with DCH's policies and procedures;
(4) Assists individuals in completing and submitting the full single streamlined application and understanding any documentation requirements; and
(5) Has not been disqualified by DCH.

As part of the PE process, the QH will email the complete PE packet to DCH at pecorrections@dch.ga.gov, within five (5) business days of the PE completion, regardless if the PE application was approved or denied.

202 Summary of Process

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

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

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

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

203 Certification Process and Liability

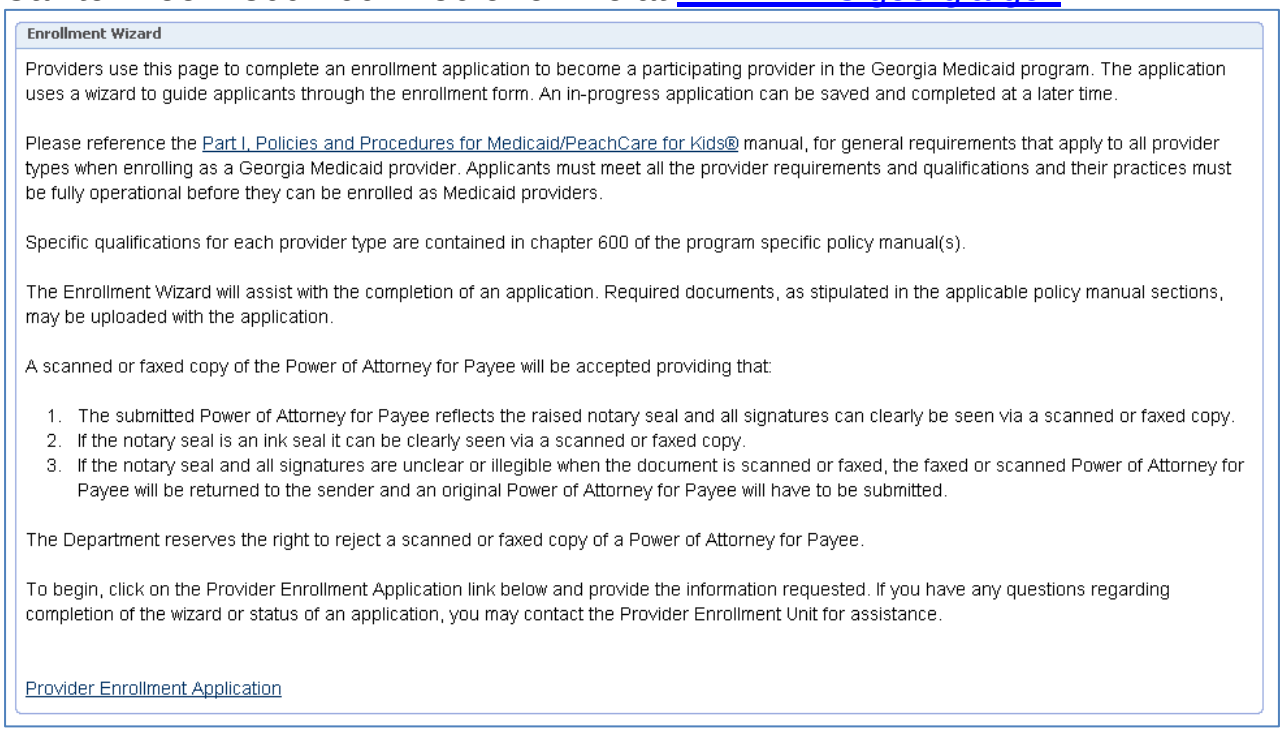
Per the Affordable Care Act (ACA), hospitals who meet the requirements of participation will be given the opportunity to become Qualified Hospitals by completing PE Medical Assistance training. The training requirement is met by attending a presumptive workshop and satisfactorily performing the training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

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

A hospital interested in becoming a QH should contact:

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

203.1 Disqualification of a Hospital

DCH must take action, including, but not limited to, disqualification of a hospital as a qualified hospital if DCH determines that the hospital is not:

1. Making, or is not capable of making, PE determinations in accordance with applicable DCH policies and procedures; or
2. Meeting the DCH standard.
3. DCH may disqualify a hospital as a qualified hospital after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

204 Responsibilities of a Qualified Hospital

- Make correct determinations of PE Medical Assistance;

- Email the complete PE Medical Assistance packet securely to DCH at pecorrections@dch.ga.gov, within five (5) business days of the PE determination results;

- Assist the applicant in completing a signed Single Streamlined Medical Assistance application;

- Inform the applicant in writing of the results of the PE Medical Assistance determination;

- Do not delegate the authority to determine PE to another entity.

205 2023 Hospital Presumptive Eligibility (HPE) Training Schedule

Training for 2023 will be webinar trainings held via Microsoft Teams. New employees need to attend one *HPE Training* to become certified in the HPE program. Other veteran staff are welcomed to attend a *HPE Training*. Employees who are audited and have two or more errors in an audit month, will be required to attend the next *HPE Training*.

Sign-up will be required to attend the *HPE Training*. The sign-up link will be sent to all PE Coordinators approximately four weeks prior to the training dates listed below. These dates are subject to change.

HPE Training (sign-up required)
The following trainings will be held from 9:30 am – 3:30 pm. The Microsoft Teams invite, and training material will be sent two days prior to the training dates listed below to all individuals who sign-up.
March 9, 2023
May 18, 2023
August 17, 2023
October 19, 2023

If you have any questions about training, please contact Kunita Snead at Kunita.snead@dch.ga.gov.

206 Services

PE provides Medical Assistance reimbursement for most services. PE does not cover labor and delivery services.

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

to the DCH's fiscal agent, Gainwell Technologies.

For applicants approved for PE Pregnant Women, some dental coverage is included. For dental coverage, applicant should be given the DMA 635 form, *Attestation of Pregnancy* to have her doctor complete. Applicant should give the completed from to her dentist. Only limited services are covered.
Note: Dental coverage ends the day pregnancy is terminated.

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

CHAPTER 300 GENERAL PROGRAM REQUIREMENTS

301 Right to Apply

§435.906 Opportunity to apply.

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

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

If the applicant is already active on another Medical Assistance Class of Assistance (COA), inform the applicant they are already active. PE is temporary Medical Assistance; therefore, do not complete a PE Medical Assistance application when the applicant is already active on full Medical Assistance except for Planning for Healthy Babies® (P4HB) aid categories 180 (Inter-Pregnancy Care-IPC) or 181 (Family Planning-FP). Refer to Appendix C for a brief overview of the COA.

If the applicant is active on P4HB (IPC or FP), complete the PE application, add approved PE to GAMMIS, complete the *PE Manual Updates* form to indicate 'Terminate P4HB' and email form along with 632H securely to DCH at pecorrections@dch.ga.gov.

If applicant is pregnant and active on Women's Health Medical Assistance (WHM), please inform applicant to contact DFCS to report pregnancy or QH can send secure email to womenshealth@dhs.ga.gov.

If applicant is pregnant and active on SSI, QH should complete the *SSI Pregnant Women Update* form and send form securely to DCH at pecorrections@dch.ga.gov.

If applicant is pregnant and active on QMB or SLMB, complete the PE application, add approved PE to GAMMIS, send PE packet securely to DCH at pecorrections@dch.ga.gov and in the body of the email, indicate applicant is active on Q-track also.

If applicant is pregnant and active on QI-1 or QDWI, have applicant complete the full Medical Assistance application (94a) only and send application securely to DCH at pecorrections@dch.ga.gov. **Subject line:** QI-1 or QDWI/Pregnant Applicant

If applicant is active on Inmate Medicaid, complete the PE application, ask applicant the release date, **DO NOT** add PE to GAMMIS, send release date and 632H securely to Kunita Snead at Kunita.snead@dch.ga.gov.

All other active Medical Assistance members are to be referred back to DFCS with their updates.

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

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

PE policy does not allow for Emergency Medical Assistance (EMA) to be approved as PE. An applicant may not be refused a PE application if they are not a US Citizen, US National, or not a qualified immigrant.

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

302 Confidentiality

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

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

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

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

Rule for enforcement purposes.
- Uses or disclosures that are required by other law.

Each applicant will receive the Notice of Privacy Practices Form. HIPAA resource information can be found at: http://dch.georgia.gov/hipaa-privacy-notices.

303 Non-Discrimination

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

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

304 Notice and Informing

§435.913 Notice of agency's decision concerning eligibility.

An applicant is entitled to adequate notice of the results of the PE determination. They must be informed that their application for Medical Assistance has been forwarded to the DFCS for a formal determination of eligibility.

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

305 Fair Hearing Rights

§431.205 Provision of hearing system.

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

An applicant is entitled to a fair hearing when DFCS makes a decision on their application for ongoing/retroactive Medical Assistance benefits.

306 Planning for Healthy Babies® (P4HB)

The Center for Medicare and Medicaid Services (CMS) approved a 10-year extension in August 2019 to the Planning for Healthy Babies® (P4HB) 1115

Demonstration Waiver. The P4HB demonstration covers Family Planning services to women ages 18 through 44 who are at or below 211 percent of the federal poverty level (FPL), who are U.S. Citizens and Georgia residents, who do not qualify for other Medicaid benefits and any other insurance coverage with the exception of vision or dental insurance, including Medicare or PeachCare for Kids®.

There are three levels of service under P4HB – Family Planning Services 181, Inter-Pregnancy Care Services 180, and Resource Mother 182-183 Services. P4HB covers Inter-Pregnancy Care (IPC) services, including primary care case management, for eligible women who have delivered a very low birth weight baby (VLBW) (birth weight less than 3 pounds 5 ounces) within three years of application date. Women, actively receiving Medical Assistance, that have delivered a VLBW baby, may receive services in the Resource Mother (RM) component of P4HB.

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

All applicants for PE Medical Assistance should be informed about P4HB, regardless, if they are approved or denied. Applicants can apply for P4HB online at www.gateway.ga.gov. Applications can be picked up at a local Health Department or local DFCS office.

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

Division of Family and Children Services
Customer Contact Center
P.O. Box 4190
Albany, GA 31706
Fax: 912-632-0389

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

See the P4HB post cards located in Appendix R.

See the Family Planning policy manual located on the GAMMIS web portal.

CHAPTER 400 APPLICATION AND ENROLLMENT PROCESS

401 Procedural Responsibilities of a Qualified Hospital

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

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

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

   - advise the applicant they may be eligible for Medical Assistance benefits as a PE member and for full Medical Assistance benefits for ongoing and retroactive Medical Assistance coverage;

   - obtain adequate information from the applicant to complete the PE application (form 632H) and the HIPAA form (form 5460);

   - determine if the applicant meets the PE Medical Assistance eligibility criteria;

   - assist an applicant with completing the Single Streamlined Medical Assistance application and obtain the applicant's signature. If the applicant has proof of identity and/or citizenship obtain a copy for the Medical Assistance application. Refer to section 502 for the complete list of acceptable citizenship/qualified immigrant/identity documents.

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

   - perform an on-line entry of the application in GAMMIS or complete the *PE Manual Updates* form and send to DCH the same day the PE application was completed, for data entry when a QH does not have internet access to GAMMIS

   - provide the applicant with the Notice of Action-Approval form (634H) and a copy of the temporary Medical Assistance certificate;

   - email a copy of the complete PE Medical Assistance packet to DCH within five (5) business days upon completion of the PE Medical Assistance determination;

- inform the applicant of the PE period;

- provide the applicant with a copy of the HIPAA notice, Notice of ADA/Section 504 Rights, Quick Guide on PE Medical Assistance and *Understanding Medical Assistance* booklet, which explains the program and gives additional information;

- provide the applicant with the address and telephone number of the local DFCS office;

- provide the applicant with the P4HB information.

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

- inform the applicant verbally and in writing via form 634H that they are not presumptively eligible;

- advise the applicant that if their circumstances change, they may have another determination of PE performed by a QH;

- inform the applicant that their application for Medical Assistance has been forwarded to the DFCS office for a formal determination of eligibility;

- forward the completed and signed PE Application (632H), HIPAA form (5460)-signature page, Notice of Action-denial (634H), Notice of ADA/Section 504 Rights and the Single Streamlined Medical Assistance application (94a) to DCH;

- provide the applicant with the address and telephone number of their DFCS office;

- provide the applicant with the HIPAA notice, Notice of ADA/Section 504 Rights and P4HB information.

APPROVED PE MEMBERS REPORTED CHANGES

For any certified presumptively eligible member who needs to report a change of address, the QH shall complete the *PE Manual Updates* form and send to DCH along with the 632H.

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

Approved PE members will be auto enrolled into a CMO (Amerigroup, CareSource or Peach State) if approved for ongoing and/or retroactive Medical Assistance benefits. Inform them to talk to their providers regarding which Medical Assistance they accept so they know which CMO to choose.

CHAPTER 500 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

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

501 Determination of Budget Group

Non-income requirements for PE include Citizenship/Immigration status; Georgia Resident; pregnancy statement (for Pregnant Women); the appropriate age or being a Former Foster Care member when required by regulations.

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

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

Definitions

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

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

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

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

PARENT- natural, adoptive or step.

CARETAKER RELATIVE– any nonparent adult that a child is living with and who assumes primary responsibility for the dependent child's care (as

may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes).

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

(1) Is under the age of 19;

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

SIBLING- natural, adoptive or step.

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

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

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

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

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

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

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

Three (3) exceptions for claimed tax dependents:

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

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

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

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

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

502 Citizenship/Immigration Status

§435.406 Citizenship and alienage

Policy

Citizenship/Immigrant status requirements are part of the PE program. Only Citizens/Nationals of the United States and Qualified Immigrants may qualify for PE Medical Assistance. Qualified immigrants that may qualify for Medicaid are:

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

    a. Lawful permanent residents

    b. Asylees, refugees, Cuban/Haitian entrants, immigrants granted parole in the U.S. for at least one year, immigrants whose deportation is being withheld, battered immigrants or victims of severe form of trafficking

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

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

    a. Lawful permanent residents for 5 or more years (beginning from date of entry)

    b. Asylees, refugees, Cuban/Haitian entrants, immigrants granted parole in the U.S. for at least one year, immigrants whose deportation is being withheld, battered immigrants or victims of severe form of trafficking

    c. Lawful permanent residents with 40 qualifying quarters of employment (10 years) and have not received any federal means tested benefits during that time. The employment test may be met also by the individual's spouse or parent.

    d. Honorably discharged U.S. Veterans or active-duty military personnel, their spouses, or unmarried dependent children.

3. 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.

4. Ukrainian nationals who enter the United States as parolees on or between February 24, 2022, and September 30, 2023. They do not have to meet the 5-year requirement. Note: Ukrainians granted Temporary Protected Status (TPS) or have pending applications for TPS are not considered qualified immigrants.

Procedures

QH must have all applicants declare citizenship/immigration status by checking 'Yes' or 'No', read *Sworn Statement* and sign PE application. As with income, the applicant's statement of citizenship/immigration status is acceptable. Verification of citizenship/immigrant status is not required; however, if the applicant does provide proof of citizenship/immigration status at the PE interview, copies should be made. One retained in the hospital file and one emailed to DCH securely with the complete PE packet to pecorrections@dch.ga.gov.

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

No Identity Required on these Citizenship Verifications:

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

Identity Required with these Citizenship Verifications:

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

Card (I-873)
- Final Adoption Decree
- Evidence of civil service employment by the US government
- Official Military record
- Federal or State census record showing US citizenship indicating a US place of birth
- Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs
- Statement signed by the physician or midwife who was in attendance at the time of birth
- One of the following documents created at least 5 years before the application for Medical Assistance showing a US place of birth:
    - Extract of hospital record on hospital letterhead established at the time of person's birth
    - Life, health or other insurance record
    - An amended US public birth record
    - Medical clinic, doctor or hospital record indicating a US place of birth
    - Institutional admission papers from nursing home, skilled nursing care facility or other institution

Acceptable Verification of Identity:

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

Applicants should not be denied PE or the right to apply for the program because they cannot provide proof of citizenship/immigration status. The application should be denied when they indicate that they are not a U.S. Citizen/U.S. National or not a qualified immigrant. An affirmative entry on

the Single Streamlined application (94a) meets the criteria for citizenship/ immigrant status. If the applicant declares 'Yes' for citizenship/immigration status for individual(s) in BG, the individual(s) will be determined presumptively eligible provided that they met the other eligibility requirements; the family net taxable income is at or below the allowable the Federal Poverty Level (FPL) income limit; they state they are pregnant; they are Georgia residents; they are a Former Foster Care members and are the appropriate age per regulations.

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

If the applicant is verbally unable to confirm citizenship or that they are not a qualified immigrant, then the QH will deny the PE Medical Assistance application and email the PE packet to DCH. DFCS will make a full determination for Emergency Medical Assistance (EMA). EMA cannot be completed in PE. QH will follow the procedures outlined in Chapter 703.

The applicant must be afforded the full opportunity to apply for PE Medical Assistance. This means all forms normally given during the course of the application process must be completed (PE Application-form 632H, HIPAA-form 5460 and the Single Streamlined Medical Assistance application-form 94a).

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

CHAPTER 600 FINANCIAL ELIGIBILITY REQUIREMENTS

601 Definition of Income

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

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

Income may be received weekly, bi-weekly, semi-monthly, monthly, or some other payment schedule. Income received other than monthly must be converted to a monthly amount to perform the income comparison test for PE. The following table shows the conversion factor to use when determining monthly income. Deductions are calculated with the same conversion factor below.

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

602 Non-Taxable Income

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

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

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

603 Income Eligibility Limits

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

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

Modified Adjusted Gross Income Limits Effective March 1, 2022

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	57	310	1,507	1,688	2,322	N/A
2	77	457	2,030	2,274	3,128	3,357
3	96	551	2,553	2,860	3,935	4,223
4	116	653	3,076	3,446	4,741	5,088
5	136	752	3,599	4,032	5,547	5,953
6	155	826	4,122	4,618	6,354	6,819
7	175	903	4,646	5,204	7,160	7,684
8	195	970	5,169	5,790	7,966	8,549
9	214	1,034	5,692	6,376	8,773	9,415
10	234	1,113	6,215	6,963	9,579	10,280
11	254	1,194	6,738	7,549	10,385	11,145
12	273	1,244	7,261	8,135	11,192	12,011

To be presumptively eligible for Medical Assistance benefits, the monthly budget group net income must not exceed the monthly income standard 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 deductions.

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

604 Determination of MAGI-based Income

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

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

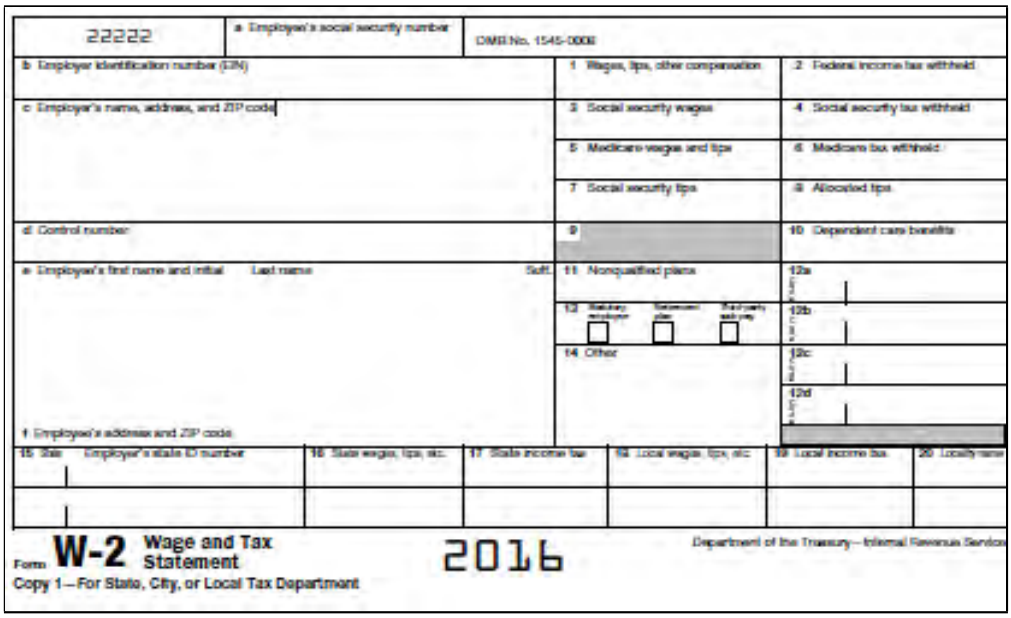
The three allowable deductions are:

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

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

Pre-tax Deductions

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



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

Form **W-2** Wage and Tax Statement **2016** Department of the Treasury—Internal Revenue Service

Copy 1—For State, City, or Local Tax Department

1040 Deductions:

Are located on the IRS Tax Return form 1040:

Adjustments to Income	23	Educator expenses	23		
	24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106	24		
	25	Health savings account deduction. Attach Form 8889	25		
	26	Moving expenses for members of the Armed Forces. Attach Form 3903	26		
	27	Deductible part of self-employment tax. Attach Schedule SE	27		
	28	Self-employed SEP, SIMPLE, and qualified plans	28		
	29	Self-employed health insurance deduction	29		
	30	Penalty on early withdrawal of savings	30		
	31a	Alimony paid **b** Recipient's SSN ►	31a		
	32	IRA deduction	32		
	33	Student loan interest deduction	33		
	34	Reserved	34		
	35	Reserved	35		
	36	Add lines 23 through 35			36

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 71479F **Schedule 1 (Form 1040) 2018**

Note: Divorces and separations finalized or modified before January 1, 2019, include alimony as income and allow as a deduction. Divorces and separations finalized or modified on or after January 1, 2019, do not include alimony as income and do not allow as a deduction.

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 comparison test, consider net income to be the total profit from the business. Net income is determined by deducting business expenses (those costs directly related to producing the goods or services that are allowable IRS deductions). The applicant's statement regarding gross income, receipts and costs of doing business, is accepted as establishing the amount of net income to be included in the financial calculation. The applicant may state an amount equal to the net income amount for a stated period.

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

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

See Appendix I for a chart Income.

Fluctating Income
Paid/Receives $150, $165, $200 = 150 + 165 + 200 = 515 / 3 = $171.66
gross weekly = $171.66 x 4.3333 = $743.85
gross bi-weekly = $171.66 x 2.1666 = $371.91
gross twice a month = $171.66 x 2 = $343.32

CHAPTER 700 PROCEDURES FOR PROCESSING APPLICATIONS

701 On-Line Procedures

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

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

702 Approvals

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

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

1. Enter the data from the PE application in the appropriate fields. When processing over the Internet, the member's identification number will be issued by the system if they don't already have a number.

2. If all data are entered correctly, the system will allow production of a temporary Medical Assistance certificate. Give the applicant a copy of the temporary Medical Assistance certificate and Notice of Action-Approval (634H). In addition to serving as a temporary Medical Assistance certificate, this document serves as a notice to the applicant that they are approved for Medical Assistance. Instruct the applicant to present this document to his/her provider as proof of Medical Assistance eligibility.

3. Within five (5) business days of completing the PE application, email the PE packet to DCH at pecorrections@dch.ga.gov. The DFCS office will review the member's eligibility for ongoing and retroactive Medical Assistance (if requested).

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

After the system accepts the information and issues a member identification number if applicable, 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 DCH.

QH should complete *the PE Manual Updates* form and email along with the PE application (632H) to DCH at pecorrections@dch.ga.gov. Complete only the section(s) that need to be updated. 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.

The *PE Manual Updates* form can be found in Appendix F and are located on the GAMMIS web portal.

702.1 Manual Approvals

Only approved applications are to be sent to GAMMIS for data entry. The manual procedure is to be followed only when the qualified hospital does not have access to the internet or error occurs when trying to add PE eligibility to GAMMIS.

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

1. Complete a form 634H, Notice of Action-Approval and give the applicant a copy. Let them know that they should present this approval notice to their medical care and pharmacy providers.

2. Complete the PE Manual Updates form and email along with the PE application (632H) to DCH. Only complete the section(s) on the form that need to be updated.

3. Within five (5) calendar days of completing the PE application, email the PE packet to DCH at pecorrections@dch.ga.gov.

PE Packets Include:
PE Application (632H)
Notice of Action - Approval (634H)
HIPAA (5460) (signature page only)
Notice of ADA/Section 504 Rights
Single Streamlined Medical Assistance Application (94a)
Third Party Liability (DMA 285), if applicable
Any verification applicant provides

703 Denied Applications

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

Reasons for denial are:

1) The applicant is not a U.S. Citizen, U.S. National, or qualified immigrant.
2) The applicant's net family taxable income is above the allowable percentage of the federal poverty level limit.
3) The applicant is not a Georgia resident.
4) The applicant is not the appropriate age for the PE Medical Assistance.
5) The applicant is not a Former Foster Care child
6) The applicant states she is not pregnant.
7) The applicant refuses to verbally give tax status information, unable to determine.

After the qualifying member, has been entered, on the GAMMIS system, then the denied member is entered, and the correct denial reason can be selected from the drop-down box. If after the completion of a PE application form 632H, and it is determined that there are no qualified applicants, the application is to be **denied** for PE. Then, adhere to the

following instructions:

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

2. Within five (5) business days of completing the PE application, email the PE packet to DCH at pecorrections@dch.ga.gov.

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

PE Packets Include:
PE Application (632H)
Notice of Action - Denial (634H)
HIPAA (5460) (signature page only)
Notice of ADA/Section 504 Rights
Single Streamlined Medical Assistance Application (94a)

APPENDIX A - QUESTIONS & ANSWERS

1. Can I use the 94a – Single Streamlined Medical Assistance application for applicants applying for PE only?

   No, you must use the 632H (PE application) for all individuals applying for PE.

2. Do I need a separate Declaration of Citizenship/Immigration Status Form 216 if I am using the Single Streamlined Medical Assistance application form?

   No, a separate Declaration of Citizenship form is not needed. Applicants can declare citizenship/immigration status with the 632H and 94a-Single Streamlined Medical Assistance applications.

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

   No, they can declare their citizenship/immigration status on the PE application.

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

   - Not being a Georgia Resident
   - Not being a U.S. Citizen, U.S. National or qualified immigrant
   - Not being at or below the appropriate FPL income limit
   - Not being the appropriate age
   - Not being a Former Foster Care child
   - Not being pregnant per applicant's statement
   - Unable to determine, applicant refuses to verbally give tax status information

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

    - Inform the applicant verbally and in writing that they have been approved.
    - Explain what PE Medical Assistance is and what it covers.
    - Give the applicant a temporary Medical Assistance certificate and explain how they should use it.
    - Explain the Single Streamlined Medical Assistance application (94a) will be given to the DFCS team to make the ongoing/retroactive Medicaid determination.
    - Also, give the applicant the Notice of Action (634H), HIPAA notice (5460), Notice of ADA/Section 504 Rights, Quick Guide on PE Medical Assistance, *Understanding Medical Assistance* booklet.
    - Provide the applicant with the P4HB information.

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

    - Inform the applicant they have been denied, and why.
    - Explain to them that if their circumstances change, they may have another determination for PE performed by the QH.
    - Give them Notice of ADA/Section 504 Rights, HIPAA notice, form 634H - Notice of Action-Denial and/or GAMMIS Denial Notice.
    - Explain the Single Streamlined Medical Assistance (94a) application form will be given to the DFCS office to make the ongoing/retroactive Medical Assistance determination, if completed.
    - Provide the applicant with the P4HB information.

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

    No. If the QH has access to the online web portal internet they must enter the application information online. This is also how the temporary Medical Assistance certificate will be generated. If the QH

does not have access to the online internet application, then the approved applications are entered by **DCH;** refer to section 702.1 for more detail.

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

   QH should screen applications to confirm the applicant is not active on Medical Assistance. If the applicant is active on Medical Assistance (except P4HB 180 or 181) do not complete a PE application, as PE is only temporary Medical Assistance. Refer to section 301 for more detail.

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

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

   The QH should follow the procedures outlined in Chapter 700.

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

    See step by step process in Appendix G.

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

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

    See Appendix I – Treatment of Income Chart.

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

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

13. How do I order forms?

    Forms 632H (PE Application), 634H (Notice of Action –

Approval/Denial), 5460 (HIPAA), DMA 285 (Third Party Liability), Quick Guide on PE Medical Assistance, SSI Pregnant Women and PE Manual Updates can be printed from the web portal.

Single Streamlined Medical Assistance applications (94a) should be obtained through DFCS.

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

Applicants should contact DFCS for questions regarding P4HB:
Phone: 1-877-427-3224
Fax: 912-632-0389
Website: https://medicaid.georgia.gov/planning-healthy-babies

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

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

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

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

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

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.

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

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

"Green Card."

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

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

17. When does time as a Permanent Resident begin?

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

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



Previous Permanent Resident Cards



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

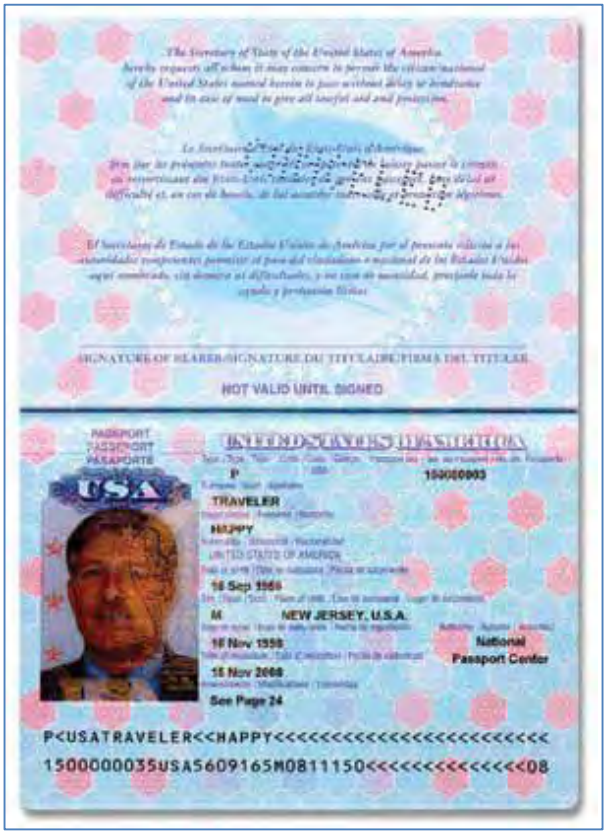
19. What is a passport?

The U.S. Department of State issues the U.S. passport to U.S. citizens and non-citizen nationals.

Current U.S. Passport



Older U.S. Passport



U.S. Passport Card

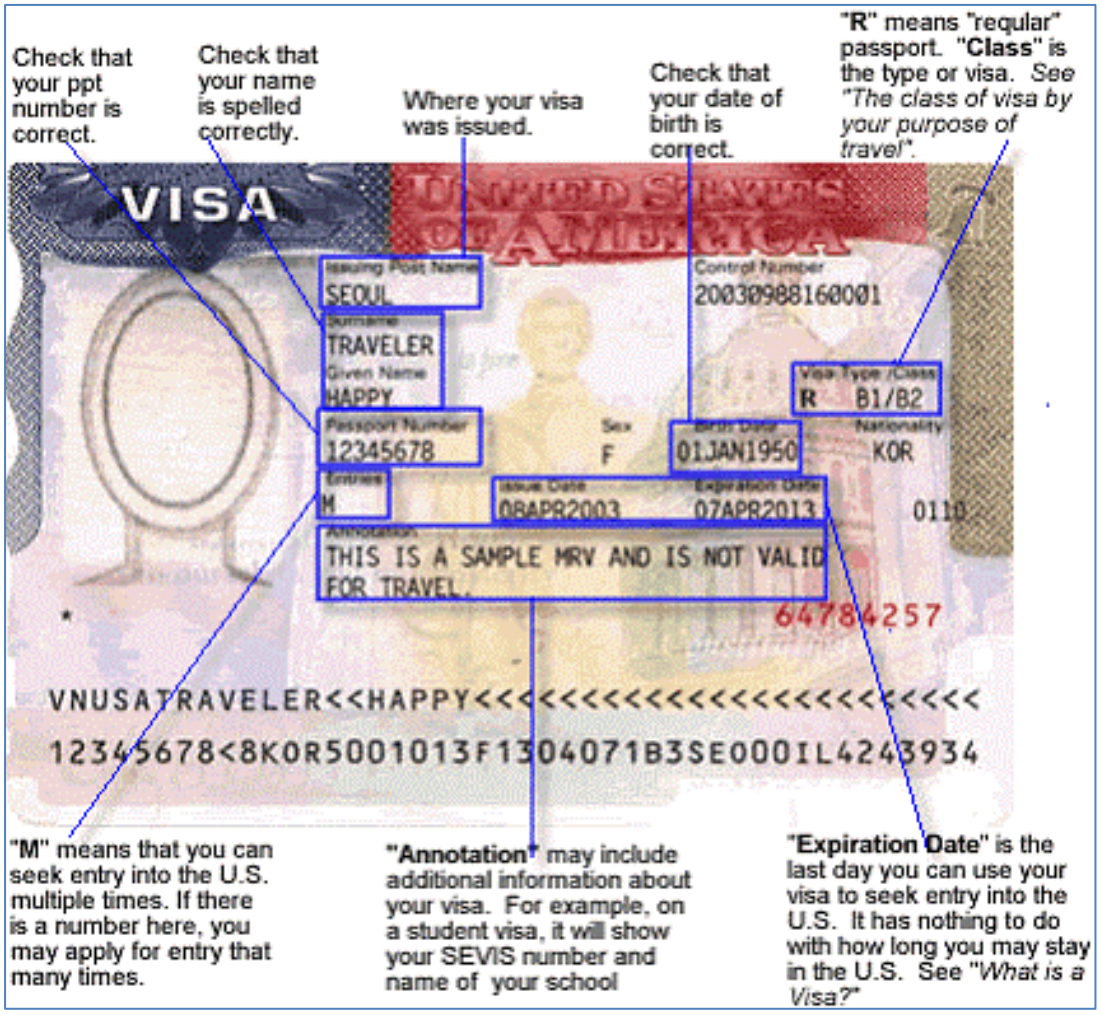
The U.S. Department of State began producing the passport card in July 2008. The passport card is a wallet-size card that can only be used for land and sea travel between the United States and Canada, Mexico, the Caribbean, and Bermuda.





20. 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 an 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.



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

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

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

2. J Visa: Academic Studies as an Exchange Visitor
For people who will be participating in an exchange visitor program in the U.S. The J Visa is the primary visa for educational and cultural exchange programs.

3. M Visa: Non-Academic or Vocational Studies
For people who want to study or train at non-academic institutions in the U.S. such as vocational schools.

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

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

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

Visitor VISA

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

APPENDIX C- CLASS OF ASSISTANCE

DCH AID CATEGORIES In GAMMIS

Medicaid and other aid categories are three digits in length with the first digit representing the type of eligibility.

First Digit Categories:
1 = Family Medicaid
2 = A B D Medicaid
3 = SSI
4 = SSI ExParte Determination
5 = Refugee
6 = Q Track
7 = PeachCare
8 = Presumptive
9 = Conversion
*Note: Refer to last page for process.

FAMILY MEDICAID

104	LIM – ADULT (Parent/Caretaker with Children)
105	LIM – CHILD (Parent/Caretaker with Children)
118	LIM 1st YR, TRANS MED ASSIST - ADULT
119	LIM 1st YR, TRANS MED ASSIST - CHILD
120	LIM 2nd YR TRANS MED ASSIST - ADULT
121	LIM 2ndYR TRANS MED ASSIST - CHILD
122	4 MO EXTENDED – CS ADULT
123	4 MO EXTENDED – CS CHILD
124	UCCP- UNCOMPENSATE CARE POOL - ADULT
125	UCCP- UNCOMPENSATED CARE POOL - CHILD
126	STEPCHILD
131	CHILD WELFARE FOSTER CARE
132	STATE FUNDED ADOPTION ASSIST
133	IV-E FOSTER CARE
134	IV-E ADOPTION ASSISTANCE
135	NEWBORN CHILD
136	PCK/MA (6-19 years of age at 113-133% FPL)
137	PCK/MA FOSTER CARE
138	PCK/MA DJJ
139	PCK/MA DJJ/RYDC
140	PCK/MA IVB CHILDREN
141	PCK/MA ELE (113-133% FPL)
142	PCK/MA Foster Care ELE
143	PCK/MA DJJ ELE
144	PCK/DJJ/RYDC ELE
145	PCK/MA IVB CHILDREN ELE
147	FAMILY MEDICALLY NEEDY SPENDDOWN - CHILD
148	PREG. WOMAN MEDICALLY NEEDY SPENDDOWN
150	DEPARTMENT OF JUVENILE JUSTICE
151	CHAFFEE MEDICAID
152	FORMER FOSTER CARE CHILDREN
153	WAIVER CHILD WITH A FOSTER CARE PLACEMENT

154	WAIVER CHILD WITH A DEPARTMENT OF JUVENILE JUSTICE PLACEMENT
155	WAIVER CHILD WITH AN ADOPTION ASSISTANCE PLACEMENT
156	WAIVER CHILD THAT HAS LOST FOSTER CARE PLACEMENT
157	WAIVER CHILD THAT HAS LOST DEPARTMENT OF JUVENILE JUSTICE PLACEMENT
158	Department of Juvenile -RYDC Placement
159	IV-B FC CHILDREN
170	RSM PREGNANT WOMAN
171	RSM CHILD (Child under 19)
172	ELE CU19
177	FAMILY PLANNING WAIVER
194	RSM EXPANSION PREGNANT WOMAN
195	RSM EXPANSION CHILD < 1
196	RSM EXPANSION CHILD WITH DOB </= 10/01/83
197	RSM PREG WOMAN, INCOME > 185 FPL

WAIVERS

251	ICWP – INDEPENDENT CARE WAIVER
256	NOW – NEW OPTION WAIVER SERVICE
257	COMP – COMPREHENSIVE SERVICES
259	CCSP – COMMUNITY CARE WAIVER

ABD MEDICAID

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
228	DISABLED ADULT CHILD – BLIND
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 AGED 60-64 – AGED
234	WIDOWER AGED 60-64 – BLIND
235	WIDOWER AGED 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. NEEDY SPENDDOWN -AGED
243	ABD MED. NEEDY SPENDDOWN- BLIND
244	ABD MED. NEEDY SPENDDOWN - DISABLED
245	WOMEN'S HEALTH MEDICAID
246	GMWD
247	DISABLED CHILD - 1996
250	DEEMING WAVIER
252	MENTAL RETARDATION WAIVER
253	LAURENS CO. WAIVER
254	HIV WAIVER
255	CYSTIC FIBROSIS 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 SPENDDOWN -AGED
287	LTC MED. NEEDY SPENDDOWN- BLIND
288	LTC MED. NEEDY SPENDDOWN - DISABLED
289	INSTITUTIONAL HOSPICE - AGED
290	INSTITUTIONAL HOSPICE - BLIND
291	INSTITUTIONAL HOSPICE - DISABLED

SSI MEDICAID

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
308	SSI WORK CONTINUANCE – BLIND
309	SSI WORK CONTINUANCE - DISABLED
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

SSI EX-PARTE DETERMINATION MEDICAID

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
471	RSM CHILD
449	PA WAIVER SERVICES
460	QUALIFIED MEDICARE BENEFICIARY
466	SPECIFIED LOW INCOME MEDICARE BENEFICIARY

REFUGEE MEDICAID

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
575	REFUGEE MED. NEEDY SPENDDOWN
595	REFUGEE RSM EXPANSION CHILD < 1
596	REFUGEE RSM EXPANSION CHILD WITH DOB </= 10/01/83

Q TRACK MEDICAID

660	QUALIFIED MEDICARE BENEFICIARY– QMB
661	SPECIFIED LOW INCOME MEDICARE BENEFICIARY – SLMB
662	QI1 BENEFICIARY– QI1
663	QI2 BENEFICIARY
664	QUAL.DISABLED WORKING INDIVIDUAL – QDWI

PEACHCARE

700	ACA PCK 101-150% FPL (INACTIVE AS OF 6/30/22)
701	ACA PCK 151-200% FPL (INACTIVE AS OF 6/30/22)
702	ACA PCK 201-235% FPL (INACTIVE AS OF 6/30/22)
703	ACA PCK >235% FPL (INACTIVE AS OF 6/30/22)
790	PEACHCARE 134 – 150 % FPL
791	PEACHCARE 151 – 200% FPL
792	PEACHCARE 201 – 247% FPL
793	PEACHCARE > 247% FPL
794	360 FC PEACH 134–150% FPL
795	360 FC PEACH 151-200% FPL
796	360 FC PEACH 201-247% FPL
797	360 FC PEACH > 247% FPL
798	ELE PCK 236 - 247% FPL
799	ELE 360 PCK 236 - 247% FPL

P4HB

180	P4HB INTER PREGNANCY CARE
181	P4HB FAMILY PLANNING ONLY
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD

CBAY

258	COMMUNITY BASED ALTERNATIVE FOR YOUTH

HOSPTIAL PRESUMPTIVE

801	PE ADULT PARENT/CARETAKER WITH CHIL(REN)
802	PE CHILD OF PARENT/CARETAKER WITH CHILD(REN)
806	PE CHILDREN UNDER AGE 19
852	PE FORMER FOSTER CARE CHILD

PRESUMPTIVE / OTHER MEDICAID

800	WOMEN HEALTH MEDICAID (WHM)
835	NEWBORN
836	NEWBORN (DHACS)
864	PE PREGNANT WOMAN
865	PRESUMPTIVE PREG. WOMAN
876	RSM PREG WOMAN (DHACS)
871	RSM (DHACS)
872	RSM 150 % EXPANSION (DHACS)
894	RSM EXPANSION PREG. WOMAN (DHACS)
895	RSM EXPANSION CHILD < 1 (DHACS)
896	RSM EXPANSION CHILD WITH DOB </= 10/01/83 (DHACS)
897	RSM PREG WOMAN Income > 185 % FPL (DHACS)
898	RSM Child < 1, Mother has Aid cat = 897 (DHACS)
804	LIM REI ADULT
805	LIM REI CHILD
818	TMA REI ADULT
819	TMA REI CHILD
870	EMERGENCY ALIEN – ADULT
873	EMERGENCY ALIEN – CHILD
815	INMATE
817	DISABLED INMATE
874	PREGNANT ADULT INMATE
875	CHILD INMATE

CONVERSION / DEFAULT

915	AGED MAO
916	BLIND MAO
917	DISABLED MAO
918	LIM ADULT
919	LIM CHILD
920	REFUGEE ADULT
921	REFUGEE CHILD
924	FOSTER CARE
931	CHILD WELFARE FOSTER CARE
983	AGED MEDICALLY NEEDY
984	BLIND MEDICALLY NEEDY
985	DISABLED MEDICALLY NEEDY

	INACTVE
	NEW – EFFECTIVE 10/1/22

For PE, individuals active in GAMMIS on any of the above aid categories should be referred to DFCS (www.gateway.ga.gov, 1-877-423-4746 or local office if open) except the following aid categories:

- **Q-track (660, 661)** – Complete the PE process to make a determination and send PE packet to DFCS (indicate on fax or in email, applicant active on Q-track also)
- **Q-track (662, 664)** – Only have applicant complete the 94a, send application to DFCS
- **SSI (All 300 codes**) – Complete the SSI Pregnant Women Update form and email to pecorrections@dch.ga.gov
- **P4HB (180, 181)** – Complete the PE process to make a determination, add PE to GAMMIS if eligible, send PE packet to DFCS, complete the PE Manual Update form and send this form along with 632H & Attachment A (if applicable) to pecorrections@dch.ga.gov
- **Women's Health (245)** – Refer to DFCS or you send email to womenshealth@dhs.ga.gov
- **Inmate (815, 817)** – Complete the PE process to make a determination (DO NOT add PE to GAMMIS if eligible), ask applicant for release date, send release date and 632H to DCH, send PE packet to DFCS (**Note:** DCH will verify release date, enter approved PE in GAMMIS and contact member)
- **Hospital Presumptive (801, 802, 806, 852) –** Inform applicant already active
- **Presumptive/Other Medicaid (800, 835, 864, 876, 871, 870) -** Inform applicant already active

Appendix E - Examples

Presumptive Eligibility Period

1. Ms. Smith applies in your office on 2/11/XX and is approved. Her PE eligibility period begins 02/11/XX and will end on the last day of the following month, 3/31/XX.

2. Mr. Washington applies in your office on 5/1/XX. His PE period would be 5/1/XX through 6/30/XX.

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

Budget Group Composition

1. Amber Jones who is age 17 and pregnant, lives with her mother Ms. Cathy Jones. Amber's father lives in the home also, but he is not married to Amber's mother. Amber's mother expects to file taxes separately and claim Amber as a tax dependent. Amber is applying for Medical Assistance for herself. Who is included in the budget group?

   Answer: Amber, unborn child, her mother and her father

2. Peter Long lives with his wife Samantha, her daughter (7) and two mutual children (12 & 13). Peter is employed and earns $1200.00, per month. His wife is a stay at home mom. Samantha receives $320.00 per month in child support for her daughter. Mr. Long is expected to file a tax return and claim his wife, his step-daughter and the two mutual children. Mr. Long is applying for Medical Assistance for everyone. Who is included in the budget group?

   Answer: Mr. and Mrs. Long, Samantha's daughter and the two mutual children

3. Henry is a 58-year old grandfather, applying for coverage for himself and his 10-year old granddaughter Stacey, who lives with him. He works and earns $10,000 annually. Henry will not file taxes and Stacey is not claimed by anyone as a tax dependent. Stacey receives $275 per month in child support from her father. Who is included in the budget group?

Answer: Two separate budget groups – Henry in his own budget group and Stacey in her own budget group

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

Answer: Shirley, her husband and their three children

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

Income

1. Sharon Lee lives with her husband, her daughter (18), and two mutual children (13 and 10). Sharon is unemployed. Her husband is employed and earns $1050 per month. He pays $60 per week for dental insurance. Mr. Lee files taxes jointly with his wife and claims all the children as tax dependents. Mrs. Lee applies for Medical Assistance for everybody. Determine the financial eligibility and if anyone will be eligible for PE Medical Assistance, if so what aid category.

$ 1050.00	Mr. Lee's earned income
$ -259.99	Dental Insurance/Pre-tax deduction (60*4.3333=259.99)
$ 790.01	Subtotal net income
$ -136.00	5% FPL deduction
$ 654.01	Total net income

Parent/Caretaker with Child(ren) BG of 5 income Limit = $752

All household members PE eligible for Parent/Caretaker with Child(ren)

Note: *5% FPL deduction was subtracted to make everyone eligible.

2. Mr. Shepherd lives with his 12-year-old son, and 4-year-old daughter. Mr. Shepherd is self-employed and earns $2,360 per month. Mr. Shepherd is expected to file taxes and claim the kids as tax dependents. There are no pre-tax or 1040 deductions to the best of Mr. Shepherd's knowledge. Mr. Shepherd is applying for Medical Assistance for everyone. Determine the financial eligibility and if anyone will be eligible for PE Medical Assistance, if so what aid category.

$2360.00 Mr. Shepherd's earned income (Total net income)

Parent/Caretaker with Child(ren) BG of 3 income limit = $551

Children Under Age 19 (12) BG of 3 income limit = $2553

Children Under Age 19 (4) BG of 3 income limit = $2860

The two kids are PE eligible for Children Under Age 19

Note: *5% FPL deduction was not subtracted because the kids are eligible without it.

3. Pamela is pregnant with triplets, due 9/4/22. Pamela works 36 hours per week and earns $17.50 per hour, paid weekly. She states she has $25 taken out her check every month for health insurance. She will file a tax return. Determine the financial eligibility and if she eligible for PE Medical Assistance, if so what aid category.

$17.50 x 36 = $630 x 4.3333 = $2729.97 Pamela's earned income
$25 x 4.3333 = $108.33 Health insurance

$2729.97 Pamela's earned income
$-108.33 Health Insurance/Pre-tax deduction
$2621.64 Total net income

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

Pregnant Women BG of 4 income limit - $5088

Pamela is PE eligible for Pregnant Women

Note: *5% FPL deduction was not given because Pamela is eligible without it.

Appendix F: FORMS Table of Contents

Form Number	Page Number	Form Name	Revision Date
632H (pages 1 & 2)	F-6	PE Application	08/2021
94a	F-10	Single Streamlined Medical Assistance Application (94a)	09/2017
94a SP	F-22	Single Streamlined Medical Assistance Application (94a) (Spanish)	09/2017
634H	F-37	Notice of Action (Approval)	08/2021
634H SP	F-38	Notice of Action (Approval) (Spanish)	08/2021
634H	F-39	Notice of Action (Denial)	08/2021
634H SP	F-40	Notice of Action (Denial) (Spanish)	08/2021
5460	F-41	HIPAA (English)	08/2022
5460 SP	F-48	HIPAA (Spanish)	08/2022
DMA 285	F-56	Third Party Liability	01/2016
n/a	F-58	Quick Guide on PE Medical Assistance	07/2021
n/a	F-59	Quick Guide on PE Medical Assistance (Spanish)	07/2021
n/a	F-61	PE Manual Updates	08/2021
n/a	F-62	SSI Pregnant Women Update	07/2021
n/a	F-63	Notice of ADA/Section 504 Rights	12/2020
n/a	F-64	Notice of ADA/Section 504 Rights (Spanish)	12/2020

INSTRUCTIONS ON FORM

PRESUMPTIVE ELIGIBILITY MEDICAL ASSISTANCE APPLICATION

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

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

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

Completion of Individual Items:

Effective for Services Beginning:	Enter the date the application is completed and signed.
Medical Assistance Identification Number:	Lister the twelve (12) digit number that begins with 111 or 222.
Applicant's Name:	Enter name of applicant
Applicant's Maiden Name:	Enter maiden name of applicant if applicable.
Applicant's Address (City, State, Zip Code):	Enter mailing address where card is to be sent.
County of Residence:	Enter applicant's county of residence.
Telephone Number:	Enter applicant's contact phone number.
SS Number	This field is optional.
Health Insurance:	Ask applicant if anyone in the household has other health insurance and check the corresponding box.
Former Foster Care Child:	Ask applicant if anyone in the household has been in Foster Care and check the corresponding box. If there is a Former Foster Care Child, then ask, what age did they leave foster care and what state did they receive foster care from.
Tax Filer/Non-Tax Filer Household:	Ask applicant if h/she expects to file taxes or be claimed as a tax dependent. Use the budget group flow chart to determine if BG will be tax filer or non-tax filer

	household and check Yes next to corresponding box.
Budget Group Member(s):	Enter the applicant's name on the first line. Enter other budget group member(s)' name on the remaining lines.
Date of Birth:	Enter the birth dates of all budget group member(s).
Race, Gender, Relationship to applicant:	Enter information for all budget group member(s).
US Citizen, US National or Lawfully Present Immigrant? Y/N	Ask applicant about citizenship/immigration status for all budget group member(s) and enter Yes or No.
Monthly Gross Income:	Enter the type of income: **C** = Commissions **W** = Earned income (wages or salaries) **OU** = Other unearned income **P** = Pensions **SE** = Self-employment Enter the amount of the income. Enter the frequency of the income: **A** = Annually **B** = Biweekly **W** = Weekly **SM** = Semi-monthly **M** = Monthly Convert all income to a monthly amount.
Monthly Deductions:	Enter total monthly pre-tax deductions and/or monthly 1040 deductions.
Monthly Net Income:	Enter net income for each budget group member by subtracting allowable deductions from monthly gross taxable income.
Subtotal Net Income:	Enter the total monthly net income for the budget group.
Number in Budget Group:	Enter number of person(s) included in the budget group.
Poverty Income Level:	Enter the amount of the income limit for the budget group size and Medical Assistance COA.
5% FPL Deduction:	Enter the 5% FPL of the budget group, if needed to make any person(s) in the budget group eligible.
Total Net Income:	Enter the amount remaining after the 5% FPL amount is subtracted from the subtotal net income field. Compare this amount to the poverty income level.

Eligible/Ineligible:	After comparing the Total Net Income to Poverty Income Level, if income is less, check the Eligible box. If income is more, check the ineligible box.
PE Medical Assistance COA:	If eligible, check the corresponding box for the COA.
Medical Assistance Application (94a):	Ask applicant if h/she would like to apply for full Medical Assistance and check corresponding box based on applicant's answer. If applicant says no, h/she must also initial beside the no box. **Note:** Applicants approved for Pregnant Women COA, are required to complete the 94a, therefore Yes should always be checked.
Sworn Statement of Applicant:	Have the applicant read the sworn statement and make sure they understand what they are agreeing/declaring to, sign and date application.
Qualified Hospital:	The qualified hospital enters their complete provider information (date, name, title, phone number, signature, hospital name, address and provider ID number).

Qualified Hospitals are to use this PE form 632H for all PE Medical Assistance Categories: Parent/Caretaker with Child(ren), PE Children Under 19 Years of Age, PE Pregnant Woman, PE Former Foster Care. For PE Women's Health Medical Assistance please refer to the PE WHM Manual on-line and use the PE WHM application form 632W.

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

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

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

HOSPITAL PRESUMPTIVE ELIGIBILITY MEDICAL ASSISTANCE

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

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

APARTMENT/LOT NUMBER: _____ SOCIAL SECURITY NUMBER: _____ OPTIONAL

WHAT AGE DID YOU LEAVE FOSTER CARE AND IN WHAT STATE DID YOU RECEIVE FOSTER CARE? _____

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

	TAX FILER HOUSEHOLD ◯YES ◯NO NON-TAX FILER HOUSEHOLD ◯YES ◯NO FIRST NAME MI LAST NAME SUFFIX	DATE OF BIRTH MM/DD/YYYY	* RACE	GENDER	RELATION TO APPLICANT	US CITIZEN, US NATIONAL OR LAWFULLY PRESENT IMMIGRANT? Y/N	MONTHLY GROSS INCOME				MONTHLY DEDUCTIONS		MONTHLY NET INCOME
							TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	PRE-TAX	1040	
01					SELF								
02	UNBORN CHILD - PREGNANT WITH _____ FETUS(ES) EDD _____ APPLICANT'S STATEMENT/NAME OF PREGNANT WOMAN _____												
03													
04													
05													

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAL ASSISTANCE AND THAT THE COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) WILL DETERMINE MY CONTINUING ELIGIBILITY WHEN WHEN I SUBMIT A MEDICAL ASSISTANCE APPLICATION.

I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN, U.S. NATIONAL OR LAWFULLY PRESENT IMMIGRANT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MYSELF, MY FAMILY, PREGNANCY, RESIDENCY, TAX STATUS, PRE-TAX DEDUCTIONS, 1040 DEDUCTIONS, FOSTER CARE STATUS AND INCOME.

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

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

I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS ONLINE AT WWW.GATEWAY.GA.GOV OR CALL 1-877-423-4746 (TDD/TTY 1-800-255-0135).

_____ _____
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.

632H (8/30/21)

SUBTOTAL NET INCOME =

NUMBER IN BUDGET GROUP =

POVERTY INCOME LEVEL =

5 % FPL DEDUCTION =

TOTAL NET INCOME =

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

☐ PARENT/CARETAKER WITH CHILD(REN) ☐ PREGNANT WOMEN

☐ CHILD(REN) UNDER 19 ☐ FORMER FOSTER CARE (Up to age 26)

I HAVE OBTAINED A MEDICAL ASSISTANCE APPLICATION (94A) FROM THE APPLICANT AND EMAILED IT TO PECORRECTIONS@DCH.GA.GOV. ☐ YES (Included in PE Packet) ☐ NO _____
APPLICANT'S INITIALS

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

_____ _____
DIRECT PHONE NUMBER SIGNATURE OF QUALIFIED HOSPITAL PERSONNEL

_____ _____
QUALIFIED HOSPITAL NAME AND ADDRESS QH PROVIDER ID

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

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

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

HOSPITAL PRESUMPTIVE ELIGIBILITY MEDICAL ASSISTANCE

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	*		RELATION TO APPLICANT	US CITIZEN, US NATIONAL OR LAWFULLY PRESENT IMMIGRANT? Y/N	MONTHLY GROSS INCOME				MONTHLY DEDUCTIONS		MONTHLY NET INCOME
FIRST NAME MI LAST NAME SUFFIX	MM/DD/YYYY	RACE	GENDER			TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	PRE-TAX	1040	

632H Page 2 (8/30/21)

SPECIAL NOTE TO MEMBER:

If you have not heard from DFCS about your application for Medical Assistance in 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 Gainwell Technologies Member Contact Center. Report insurance coverage to your provider when seeking medical assistance. If you have questions about payment of your medical bills, you may call toll-free 1-866-211-0950.

INSTRUCTIONS TO PROVIDER:

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

NOTICE TO OUT OF STATE PROVIDER:

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

NOTICE TO MEMBER:

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

SINGLE STREAMLINED MEDICAL ASSISTANCE APPLICATION

This form is used to apply for ongoing and retroactive Medical Assistance benefits. The applicant must complete this document as part of the Presumptive Eligibility application process. It should be included in the Presumptive Eligibility package and email the PE packet to DCH at pecorrections@dch.ga.gov. These documents are available in English and Spanish.

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.

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 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 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 2

Current Job & Income Information

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

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

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

23. Average hours worked each WEEK

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

24. Employer name and address

25. Employer phone number
( ) –

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

27. Average hours worked each WEEK

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

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

a. Type of work

_____

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

$ _____

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

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

☐ None

☐ Unemployment $ How often?
☐ Pensions $ How often?
☐ Social Security $ How often?
☐ Retirement accounts $ How often?
☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?
☐ Net rental/royalty $ How often?
☐ Other income $ How often?
Type: _____

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

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____
☐ 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**.

ATTACHMENT A

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

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

Tell us about the job that offers coverage.

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

EMPLOYEE Information

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

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ____ - _____
5. Employer address	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. Email address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

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

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

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

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

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

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

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

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

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

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

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

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

Form 94a Appendix A (9/17)

EMPLOYER COVERAGE TOOL

Georgia Department of Community Health

Form Approved OMB No. 0938-1191

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

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

EMPLOYEE Information

The **employee** needs to fill out this section.

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

EMPLOYER Information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN) _____ - _____
5. Employer address	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (If different from above) ( ) –	12. Email address

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

☐ **Yes** (Continue)

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

☐ **No** (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

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

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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

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

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

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

Form 94a Appendix A (9/17)

ATTACHMENT B

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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

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

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

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

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

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often? _____	$ _____ How often? _____

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

Form 94a Appendix B (9/17)

ATTACHMENT C

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Assistance with Completing this Application

You can choose an authorized representative.

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

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

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

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

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

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

Form 94a Appendix C (9/17)

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Solicitud para Cobertura de Salud y Ayuda Pagando el Costo

Formulario aprobado
OMB Num. 0938-1191

COSAS PARA SABER

Use esta solicitud para ver cuáles opciones de cobertura usted califica

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

¿Quién puede usar esta Solicitud?

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

Solicite más rápido en línea

Solicite más rápido en línea gateway.ga.gov.

Qué necesita para solicitar

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

¿Por qué pedimos esta

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

¿Qué pasa después?

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

Consiga ayuda para hacer esta solicitud

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

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

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

Paso 1: Cuéntenos sobre usted.

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

1. Primer nombre, segundo nombre, Apellido, & Sufijo			
2. Dirección de domicilio (Deje en blanco si no tiene una.)			3. Número del apartamento o suite
4. Ciudad	5. Estado	6. Código postal	7. Condado
8. Dirección postal (si es distinta a de domicilio):			9. Número del apartamento o suite
10. Ciudad	11. Estado	12. Código postal	13. Condado
14. Número de teléfono ( ) –		15. Otro número de teléfono ( ) –	

16. ¿Quiere recibir información por correo electrónico sobre esta solicitud? ☐ Sí ☐ No

Dirección de correo electrónico: _____

17. ¿En qué idioma prefiere hablar o escribir (si no es el inglés)?

Paso 2: Cuéntenos sobre su familia.

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

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

Incluya:

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

NO tiene que incluir:

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

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

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

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

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

1. Primer nombre, segundo nombre, Apellido, Sufijo | 2. Parentezco con usted **USTED MISMO**

3. Fecha de nacimiento (MM/DD/AAAA): | 4. Sexo ☐ Masculino ☐ Femenino

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

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

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

☐ Sí. **Si sí,** por favor, conteste las preguntas a–c. ☐ NO. **Si no,** salte a la pregunta c.

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

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

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

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

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

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

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

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

11. **Si usted no es ciudadano(a) o nacional de los Estados Unidos,** ¿es un inmigrante calificado?
☐ Sí. Llene la información de su tipo de documento y número de ID abajo.
a. Tipo de documento de inmigración_____ b. Número de ID de documento _____
c. ¿Ha vivido usted en los Estados Unidos desde el 1996? ☐ Sí ☐ No d. ¿Es usted o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? ☐ Sí ☐ No

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

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

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

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

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

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

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

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

Trabajo actual e Información de ingresos

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

☐ **No empleado**
Salte a la pregunta 28.

☐ **Trabajo por cuenta propia**
Salte a la pregunta 27.

TRABAJO ACTUAL 1:

18. Nombre y dirección del empleador

19. N° de teléfono del empleador
( ) –

20. Sueldos/propinas (antes de impuetos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual
$ _____

21. Promedio de horas trabajadas cada SEMANA

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

22. Nombre y dirección del empleador

23. N° de teléfono del empleador
( ) –

24. Sueldos/propinas (antes de impuetos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual
$ _____

25. Promedio de horas trabajadas cada SEMANA

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

27. **Si trabaja por cuenta propia, conteste las siguientes preguntas:**
a. tipo de trabajo
_____

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

28. **OTRO INGRESO:** Marque todas las que apliquen y dé la cantidad y cada cuanto la recibe.
NOTA: Usted no necesita decirnos sobre los ingresos de manutención infantil, pagos de veterano o Ingresos del Seguro Suplementario.

☐Ninguno
☐desempleo $_____ ¿Con qué _____
☐Pensiones $_____ ¿Con qué _____
☐Seguro Social $_____ ¿Con qué _____
☐Cuentas de retiro $_____ ¿Con qué _____
☐ Pesión alimentida $_____ ¿Con qué
☐Cantidad neta de pesca u cultivos $_____ ¿Frecuencia?
☐ Rental/regalis netas $_____ ¿Frecuencia
Otros ingresos $_____ ¿Frecuencia
Tipo _____

29. **DEDUCCIONES** Marque todas las que aplican y dé la cantidad y cada cuánto la paga.
Si paga por ciertas cosas que pueden ser deducidas en la declaración de impuestos federales y nos deja saber, su costo de cobertura de salud pudiera ser un poco menos.
NOTA: No debe incluir los costos netos que ya declaró en su respuesta de trabajo por cuenta propia (pregunta 27b).
☐ pensión alimenticia $_____ ¿Cada cuánto? _____ ☐ Otras deducciones $_____ ¿Cada cuánto? _____
☐ Intereses del préstamos estudiantil $_____ ¿Cada cuánto? _____ Tipo: _____

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

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

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

GRACIAS! Es todo lo que necesitamos saber de usted.

PASO 2: PERSONA 2

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

1. Primer nombre, segundo nombre, Apellido, Sufijo | 2. Parentezco con usted

3. Fecha de nacimiento (MM/DD/AAAA): | 4. Sexo ☐ Masculino ☐ Femenino

5. Número de Seguro Social (SSN)_____-_____-_____
Necesitamos esto si quiere cobertura de salud y tiene un Número de Seguro Social

6. ¿Vive con usted la PERSONA # 2? ☐ Sí ☐ No
Sino, escriba la dirección: _____

7. **¿La PERSONA # 2 planea presentar una declaración de impuestos el PRÓXIMO AÑO?**
(Aunque no presente una declaración de impuestos, usted puede solicitar para seguro de salud)

☐ Sí. **Si sí,** por favor, conteste las preguntas a–c. ☐ NO. **Si no,** salte a la pregunta c.

a. ¿La PERSONA # 2 presentará una declaración de impuestos con un cónyuge? ☐ Sí ☐ No
Si sí, nombre del cónyuge: _____

b. ¿La PERSONA # 2 va a reclamar algún dependiente en su declaración de impuestos? ☐ Sí ☐ No
Si sí, haga una lista del (los) dependiente(s): _____

c. ¿Será la PERSONA # 2 reclamada como un(a) dependiente en la declaración de impuestos de otra persona? ☐ Sí ☐ No
Si sí, por favor mencione el nombre del declarante de impuestos: _____
¿Cuál es el parentesco de la PERSONA # 2 con el declarante de impuestos? _____

8. ¿Está embarazada la PERSONA # 2? ☐ Sí ☐ No a. Si sí, ¿cual es la fecha esperada de alumbramiento __/__/__ ; y cuantos bebés está esperando? _____

9. **¿Necesita cobertura de salud la PERSONA # 2?**
(Aunque tenga seguro, puede habar un programa con mejor cobertura o un costo más bajo.)

☐ Sí. **Si sí,** conteste todas las preguntas abajo. ☐ NO. **Si no,** salte a las preguntas sobre ingresos en la página 5. Deje el resto de esta página en blanco.

10. ¿Tiene la PERSONA # 2 una condición física, mental o de salud emocional que le cause limitaciones en actividades (como bañarse, vestirse, actividades diarias, etc) o vive en un centro médico o un hogar de ancianos? ☐ Sí ☐ No

11. ¿Es la PERSONA # 2 un(a) ciudadano(a) de los Estados Unidos o nacional de los Estados Unidos? ☐ Sí ☐ No

12. **Si la PERSONA # 2 no es ciudadano(a) o nacional de los Estados Unidos,** ¿es un inmigrante calificado?
☐ Sí. Llene la información de su tipo de documento y número de ID abajo.
a. Tipo de documento de inmigración _____ b. Número de ID de documento _____
c. ¿Ha vivido la PERSONA # 2 en los Estados Unidos desde el 1996? ☐ Sí ☐ No d. ¿Es la PERSONA # 2 o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? ☐ Sí ☐ No

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

13. ¿La PERSONA # 2 quiere ayuda para pagar facturas médicas de los últimos tres meses? ☐ Sí ☐ No	14. ¿Vive la PERSONA # 2 con al menos un menor menor de 19 años y usted es el cuidador(a) principal de este menor? ☐ Sí ☐ No	15. ¿Estuvo la PERSONA # 2 en cuidado tutelar a la edad de 18 o mayor? ☐ Sí ☐ No

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

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

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

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

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

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

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

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

PASO 2: PERSONA 2

Trabajo actual e Información de ingresos

☐ **Empleado**
Si está empleado actualmente, díganos sobre sus ingresos. Empiece con la pregunta 20.

☐ **No empleado**
Salte a la pregunta 30.

☐ **Trabajo por cuenta propia**
Salte a la pregunta 29.

TRABAJO ACTUAL 1:

20. Nombre y dirección del empleador

21. N° de teléfono del empleador
( ) –

22. Sueldos/propinas (antes de impuetos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual

$ _____

23. Promedio de horas trabajadas cada SEMANA

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

24. Nombre y dirección del empleador

25. N° de teléfono del empleador
( ) –

26. Sueldos/propinas (antes de impuetos) ☐ por hora ☐ semanal ☐ cada dos semanas ☐ quincenal ☐ mensual ☐ anual

$ _____

27. Promedio de horas trabajadas cada SEMANA

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

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

a. tipo de trabajo

_____

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

$ _____

30. **OTRO INGRESO:** Marque todas las que apliquen y dé la cantidad y cada cuánto la recibe.
NOTA: Usted no necesita decirnos sobre los ingresos de manutención infantil, pagos de veterano o Ingresos del Seguro Suplementario.

☐Ninguno
☐desempleo $_____ ¿Con qué _____
☐Pensiones $_____ ¿Con qué _____
☐Seguro Social $_____ ¿Con qué _____
☐Cuentas de retiro $_____ ¿Con qué _____
☐ Pesión alimentida $_____ ¿Con qué _____

☐Cantidad neta de pesca u cultivos $_____ ¿Frecuencia?
☐ Rental/regalis netas $_____ ¿Frecuencia
Otros ingresos $_____ ¿Frecuencia
Tipo _____

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

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

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

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

32. **INGRESO ANUAL:** **Complete solo si los ingresos de la PERSONA # 2 cambian cada mes.**
Si no espera cambios en ingresos mensuales de la PERSONA # 2, agregue otra persona o salte a la próxima sección.

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

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

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

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

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

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

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

PASO 4 La cobertura de salud de su familia

Conteste estas preguntas para cualquiera que necesite cobertura de salud.

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

☐ SÍ. **Si sí,** verifique el tipo de cobertura y escriba el nombre de la persona al lado del tipo de cobertura que tienen. ☐ NO.

- ☐ Medical Assistance _____
- ☐ Medicare _____
- ☐ TRICARE (No marque si tiene cuidado directo o Line of Duty)
- ☐ Programas de cuidado de salud de Veteranos _____
- ☐ Peace Corps _____
- ☐ Seguro del empleador _____
- ☐ Nombre del seguro de salud: _____
  Número de póliza: _____
  ¿Es esta una cobertura de COBRA? ☐SÍ ☐No
  ¿Es éste un plan de salud de jubilación? ☐SÍ ☐No
- ☐ Otro
  Nombre del seguro de salud: _____
  Número de póliza: _____
  ¿Es éste un plan con beneficios limitados (como una póliza escolar de accidente)? ☐SÍ ☐No

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

☐ SÍ. **Si sí,** necesitará completar e incluir el anejo A.
☐ NO. **Sino, continúe al paso 5.**

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

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

PASO 5 Lea y firme esta solicitud.

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

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

Renovación de cobertura en los próximos años

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

Sí, renueve mi elegibilidad automáticamente por los próximos

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

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

Si alguien en esta solicitud es elegible para Asistencia Médica

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

Mi derecho a apelar

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

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

Firma	Fecha (mm/dd/aaaa)

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

PASO 6 Envíe la solicitud completa.

Envíe su solicitud firmada a la dirección abajo:

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

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

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

ANEXO A

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Cobertura de salud de los trabajos

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

Cuéntenos sobre el trabajo que ofrece la cobertura.

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

Información sobre el EMPLEADO

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

Información sobre el EMPLEADOR

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

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

☐ **Sí** (Continúe)

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

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

Nombre: _____ Nombre: _____ Nombre: _____

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

Cuéntenos sobre el plan de salud ofrecido por este empleador.

14. ¿El empleador ofrece un plan de salud que satisface el estándar del valor mínimo*? ☐ Sí ☐ No

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

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

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

16. ¿Qué cambio hará el empleador para el nuevo año del plan (si se sabe)?

☐ El empleador no ofrecerá cobertura de salud

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

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

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

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

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

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

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

HERRAMIENTA DE COBERTURA DEL EMPLEADOR

Form Approved
OMB No. 0938-1191

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

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

Información sobre el EMPLEADO

El empleado tiene que llenar esta sección.

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

Información sobre el EMPLEADOR

Pídale al **empleador** esta información.

3. Nombre del empleador	4. No. de Identificación del empleador (EIN) _____ - _____
5. Dirección del empleador	6. Número de teléfono del empleador ( ) –

7. Ciudad	8. Estado	9. Código postal

10. ¿A quién podemos contactar para hablar sobre la cobertura de salud del empleado en este trabajo?

11. No. de teléfono (si es diferente al de arriba) ( ) –	12. Dirección de correo electrónico

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

☐ **Sí** (Continúe)

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

☐ **No** (PARE y devuelva este formulario al empleado)

Cuéntenos sobre el plan de salud ofrecido por este empleador.

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

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

☐ No

(Vaya a la pregunta 14)

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

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

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

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

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

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

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

☐ El empleador no ofrecerá cobertura de salud

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

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

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

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

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

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

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

ANEXO B

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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

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

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

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

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

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

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

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

ANEXO C

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Ayuda para completar esta solicitud

Usted puede escoger a un representante autorizado.

Usted le puede dar permiso a una persona de confianza para que hable con nosotros sobre esta solicitud, para que vea su información y para que actúe como su representante en lo relacionado con esta solicitud, incluso para que obtenga información sobre su solicitud y para que firme su solicitud en su nombre.
A esta persona se le llama un "representante autorizado." Si alguna vez usted necesita cambiar su representante autorizado, llame a la División de Servicios para Familias y Niños (DFCS, por sus siglas en inglés) al 1-877-423-4746. Si usted es un representante, nombrado legalmente, de alguien que aparece en esta solicitud, presente una prueba junto con la solicitud.

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

Únicamente para consejeros, navegadores, representantes e intermediarios certificados.

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

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

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

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

NOTICE OF ACTION Form DMA 634H:

634H 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 beneficiary at the time of her PE approval. A copy of this form should be included in the PE packet and emailed to DCH at pecorrections@dch.ga.gov.

634H Denial

This form is used to provide notice to the applicant when a PE determination is denied. It is to be given to the applicant at the time they are determined not eligible. A copy of this form should be included in the PE packet and emailed to DCH at pecorrections@dch.ga.gov.

COMPLETION OF INDIVIDUAL ITEMS:

Complete the top part of the form showing identifying information:

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

Net taxable income exceeds the income standard
Not the correct age for the Medicaid
Not a US Citizen, US National or Qualified Immigrant
Not a GA resident
Not a Former Foster Care child
Not pregnant per the applicant's statement
Unable to determine, applicant refuses to verbally give tax status information.

Enter whichever reason is correct.

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

The QH should complete the bottom part and 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 Medical Assistance

_____
Date

Name _____

Address _____

City _____ State GA Zip Code _____

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

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

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

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

_____ _____
Signature of Qualified Hospital Qualified Hospital Address

_____ _____ _____
Title Phone Number Qualified Hospital ID Number

634H Approval (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

AVISO DE ACCIÓN

Presuntiva de Elegibilidad Asistencia Médica

_____
Fecha

Nombre _____

Dirección _____

Ciudad _____ Estado GA Código Postal _____

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

Se ha aprobado su solicitud para presuntiva de elegibilidad (PE) asistencia médica.

Cuando solicitó para Presuntiva de Elegibilidad (PE) Asistencia Médica, es posible que también haya solicitado Asistencia Médica continua/retroactiva. Su solicitud de Asistencia Médica se enviará a la Oficina de la División de Servicios para Familias y Niños (DFCS) para una determinación final de elegibilidad. DFCS tomarán la decisión de su solicitud de Asistencia Médica completa y le notificarán por correo.

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

Firma del Hospital Calificado	Dirección del Hospital Calificado	
Titulo	Número de Telefono	Número de Identificación del Hospital Calificado

634H Aprobación SP (Revisado el 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

NOTICE OF ACTION

Presumptive Eligibility Medical Assistance

_____
Date

Name _____

Address _____

City _____ State GA Zip Code _____

☐ **PRESUMPTIVE ELIGIBILITY DENIED**

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

The reason for denial is: Choose Item

When you applied for PE Medical Assistance, you may also have applied for ongoing/ retroactive Medical Assistance. Your Medical Assistance application will be sent to the Division of Family and Children Services (DFCS) Office for a final determination of eligibility. DFCS may determine you are potentially eligible for another type of Medical Assistance and will notify you. If you are not eligible for Medical Assistance, your Medical Assistance application will be referred to the Federally Facilitated Marketplace (FFM) for consideration. You will be notified directly by the FFM.

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

_____ _____
Signature of Qualified Hospital Qualified Hospital Address

_____ _____ _____
Title Phone Number Qualified Hospital ID Number

634H Denial (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

AVISO DE ACCIÓN

Presuntiva de Elegibilidad Asistencia Médica

_____
Fecha

Nombre _____

Dirección _____

Ciudad _____ Estado GA Código Postal _____

☐ **ELEGIBILIDAD PRESUNTIVA NEGADA**

Su solicitud para Presuntiva de Elegibilidad (PE) Asistencia Médica se ha denegado.

El motive de la negación es: Elige un articulo

Cuando solicitó para Presuntiva de Elegibilidad (PE) Asistencia Médica, es posible que también haya solicitado para asistencia médica continua/retroactiva. Su solicitud de Asistencia Médica se enviará a la Oficina de la División de Servicios para Familias y Niños (DFCS) para una determinación final de elegibilidad. DFCS pueden determinar que usted es potencialmente elegible para otro tipo de Asistencia Médica y le notificarán. Si no es elegible para Asistencia Médica, su solicitud de Asistencia Médica será remitida al Mercado Federal Facilitado (FFM) para su consideración. La FFM le notificará directamente.

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

_____ _____
Firma del Hospital Calificado Dirección del Hospital Calificado

_____ _____ _____
Titulo Número de Telefono Número de Identificación del Hospital Calificado

S34H Negación SP (Revisado el 6/30/21)

Notice of Privacy Practices
Georgia Department of Human Services

Date: August 01, 2022

THIS NOTICE DESCRIBES HOW PERSONAL 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.

Protecting your privacy is very important to us. This Notice of Privacy Practices tells you our obligations, what information we collect, how the Department may use and disclose your information, and your rights.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of your personal 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.

INFORMATION WE COLLECT:

We collect information necessary to verify identity, citizenship status, residency, income, and incarceration status. This information includes but is not limited to:

- Demographic data such as name, address, telephone number, email, and age;
- Income data such as tax filing status, marriage status, tax dependents, employer, and income;
- Citizenship and immigration data such as social security number, resident alien number, and incarceration status; and
- Medical information such as disabilities, any health insurance coverage, and other information necessary to facilitate your application for benefits/services.

HOW DHS MAY USE AND DISCLOSE PERSONALLY IDENTIFIABLE INFORMATION:

Personally Identifiable Information (PII) is collected, used, maintained, and shared by DHS. We collect PII during your application for benefits and/or services. The information provided is verified and confirmed through various sources. The following describes some ways DHS may use and disclose personally identifiable information that identifies you:

- For eligibility determination; and
- For enrollment in DHS programs;

The PII provided to DHS by clients is purposely used to determine eligibility, approve, deny, or renew public assistance benefits. The data is maintained for the purpose of renewing benefits by verifying the eligibility, support agency denial, and approval on renewal decisions. The data is shared to effectuate the purpose of the programs. We will not create, collect, use or disclose PII for any purposes that are not authorized by law.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes some ways DHS may use and disclose protected health information that identifies you ("Health Information"):

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

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.

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.

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.

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.

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.

Your written permission is necessary before your health records are shared for any other reason not authorized by law. If you do provide DHS with a written authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer at the contact information below. 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 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 DHS has is incorrect or incomplete information about you, 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 make changes, you can go through your user portal, contact customer service for the program to which you are applying, contact your case manager, or make your request, in writing, to the below referenced Privacy Officer. We encourage you to review your information on a regular basis to make sure it is correct.

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

PROTECTIONS:

DHS is committed to protecting your personal information. PII and PHI is protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized access, use, and/or disclosure of protected information. We do not sell any information given to us. We strictly adhere to a range of federal and state privacy and information security related standards designed to keep your information secure.

CHANGES TO THIS NOTICE:

DHS reserves the right to change this notice at any time. The new notice applies to 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 and/or other medical provider).

CONSENT:

By submitting your personal information to us, you agree that we may collect, use, and disclose any such information as permitted or required by law.

[SIGNATURE PAGE TO FOLLOW]

Signature Page

If you would like to acknowledge receipt of this DHS 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 Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name

Return Address:

[Insert Local Address here]

Aviso de prácticas de privacidad
Departamento de Servicios Humanos de Georgia

***Fecha*: 01 de agosto de 2022**

ESTE AVISO DESCRIBE CÓMO SE PUEDE UTILIZAR Y DIVULGAR SU INFORMACIÓN PERSONAL Y CÓMO PUEDE ACCEDER A ELLA.

LEA CON ATENCIÓN ESTE AVISO.

El Departamento de Servicios Humanos (DHS, en inglés) es una agencia del poder ejecutivo del gobierno de Georgia que se encarga de la administración de numerosos programas federales responsables del almacenamiento, uso y mantenimiento de información médica y otra 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 está obligado a cumplir esas leyes como se indica a lo largo de este aviso.

Proteger su privacidad es muy importante para nosotros. Este aviso de prácticas de privacidad le informa acerca de nuestras obligaciones, la información que recopilamos, la forma en que el Departamento puede utilizar y divulgar su información, y sus derechos.

OBLIGACIONES DEL DEPARTAMENTO DE SERVICIOS HUMANOS:

El DHS está obligado por ley a:

- Mantener la privacidad de su información personal;
- Darle este aviso de nuestras obligaciones legales y de nuestras prácticas de privacidad con respecto a su información médica; y
- Seguir los términos de nuestro aviso vigente.

INFORMACIÓN QUE RECOPILAMOS:

Recopilamos la información necesaria para verificar la identidad, condición de ciudadanía, residencia, ingresos y situación de encarcelamiento. Esta información incluye, pero no se limita a:

- Datos demográficos como nombre, dirección, número de teléfono, correo electrónico y edad;
- Datos sobre ingresos como el estado de declaración de impuestos, el estado civil, las personas a cargo de los impuestos, el empleador y los ingresos;
- Datos sobre la ciudadanía y la inmigración tales como el número del seguro social, el número de inmigrante residente y el estado de encarcelamiento; e
- Información médica como las discapacidades, cualquier cobertura de seguro médico y otra información necesaria para facilitar su solicitud de beneficios/servicios.

CÓMO PUEDE EL DHS UTILIZAR Y DIVULGAR LA INFORMACIÓN PERSONAL:

El DHS recopila, utiliza, mantiene y comparte información personal (PII, en inglés). Recopilamos la PII durante su solicitud de beneficios y servicios. La información proporcionada está verificada y confirmada a través de diversas fuentes. A continuación se describen algunas formas en las que el DHS puede utilizar y revelar información personal que le identifique:

- Para determinar la elegibilidad; y
- Para la inscripción en los programas del DHS;

La PII que los clientes proporcionan al DHS se utiliza de manera deliberada para determinar la elegibilidad, aprobar, denegar o renovar las prestaciones de asistencia pública. La información se conserva con el fin de renovar los beneficios mediante la verificación de la elegibilidad, la negación de la agencia de asistencia y la aprobación en las decisiones de renovación. La información se comparte para llevar a cabo el propósito de los programas. No crearemos, recopilaremos, utilizaremos ni divulgaremos PII para ningún fin que no esté autorizado por la ley.

CÓMO PUEDE UTILIZAR Y DIVULGAR DHS INFORMACIÓN MÉDICA:

A continuación se describen algunas formas en las que el DHS puede utilizar y divulgar información médica protegida que le identifique ("Información Médica"):

Como lo establece la ley. El DHS divulgará Información Médica cuando así lo exija la legislación internacional, federal, estatal o local.

Con fines de tratamiento. El DHS puede utilizar y divulgar Información Médica para su tratamiento y para proporcionarle servicios de atención médica relacionados con el tratamiento. Por ejemplo, el DHS puede revelar Información Médica a médicos, enfermeras, técnicos u otro personal que se encuentre involucrado en su atención médica y necesite la información para proporcionarle atención médica.

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

Personas implicadas en su cuidado o en el pago de su cuidado. Cuando sea apropiado, el DHS puede compartir Información Médica con una persona que esté involucrada en su cuidado médico o en el pago de su cuidado, como su familia o un amigo cercano. El DHS también puede notificar a su familia acerca de su ubicación o estado general o revelar dicha información a una entidad que ayude en las tareas de auxilio en caso de catástrofe.

Investigación. En determinadas circunstancias, el DHS puede utilizar y divulgar Información Médica para la investigación. Por ejemplo, un proyecto de investigación puede consistir en comparar la salud de los pacientes que recibieron un tratamiento con los que recibieron otro, para la misma enfermedad. Antes de que el DHS utilice o divulgue información médica para la investigación, el proyecto pasará por un proceso de aprobación especial. Incluso sin una aprobación especial, el DHS puede permitir a los investigadores consultar los registros para ayudarles a identificar a los pacientes que pueden ser incluidos en su proyecto de investigación o para otros fines similares, siempre y cuando no retiren o se lleven una copia de cualquier Información Médica.

Socios comerciales. El DHS puede revelar Información Médica a nuestros asociados comerciales que realizan operaciones en nuestro nombre o nos proporcionan servicios si la información es necesaria para dichas operaciones o servicios. Por ejemplo, el DHS puede utilizar los servicios de una entidad independiente para realizar servicios de informática. Todos los asociados comerciales del DHS se encuentran obligados a proteger la privacidad de su información y no se les permite utilizar o divulgar ninguna información que no se encuentre especificada en nuestro contrato.

Reclusos o individuos bajo custodia. Si usted es un recluso de una institución penitenciaria o está bajo la custodia de un agente de la ley, el DHS puede divulgar la Información Médica a la institución penitenciaria o al agente de la ley. Esta divulgación se haría si fuera necesario: (1) para que la institución le proporcione atención médica; (2) para proteger su salud y seguridad o la salud y seguridad de otros; o (3) para la seguridad de la institución correccional.

LOS USOS Y DIVULGACIONES QUE REQUIEREN QUE EL DHS LE BRINDE LA OPORTUNIDAD DE OBJETAR Y OPTAR POR NO HACERLO:

Personas implicadas en su cuidado o en el pago de su cuidado. A menos que usted se oponga, el DHS puede revelar a un miembro de su familia, a un pariente, a un amigo cercano o a cualquier otra persona que usted identifique, su Información Médica que esté relacionada de forma directa con la participación de esa persona en su cuidado médico. Si usted no puede aceptar u objetar dicha divulgación, el DHS puede divulgar dicha información según sea necesario si se determina que es para su beneficio basado en el juicio profesional del DHS.

SE REQUIERE SU AUTORIZACIÓN POR ESCRITO PARA OTROS USOS Y DIVULGACIONES:

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

1. Usos y divulgaciones de Información Médica con fines de marketing; y
2. Divulgaciones que constituyen una venta de su Información Médica.

Es necesario contar con su permiso por escrito antes de compartir su historial médico por cualquier otro motivo no autorizado por la ley. Si usted le proporciona una autorización por escrito al DHS, puede revocarla en cualquier momento si presenta una revocación por escrito al Oficial de Privacidad a través de la información de contacto que figura debajo. Al recibirla, el DHS dejará de divulgar la Información Médica conforme a la autorización. Sin embargo, la revocación no afectará a las divulgaciones realizadas de acuerdo con su autorización antes de que la haya revocado.

SUS DERECHOS:

Usted tiene los siguientes derechos en relación con la información que el DHS tiene sobre usted:

Derecho a inspeccionar y hacer copias. Tiene derecho a inspeccionar y hacer copias de la Información Médica que pueda utilizarse para tomar decisiones sobre su cuidado o el pago de su cuidado. Esto incluye los registros médicos y de facturación, que no sean notas de psicoterapia. Para inspeccionar y obtener una copia de esta Información Médica, debe presentar su solicitud, por escrito, al Oficial de Privacidad mencionado más abajo. El DHS tiene hasta 30 días para poner a su disposición su Información Médica y el DHS puede cobrarle una tarifa razonable por los costos de las copias, el envío por correo u otros suministros relacionados con su solicitud. El DHS no puede cobrarle una tasa si necesita la información para una solicitud de prestaciones en virtud de la Ley de la Seguridad Social o de cualquier otro programa estatal o federal de prestaciones basadas en las necesidades. El DHS puede denegar su solicitud en determinadas circunstancias limitadas. Si el DHS deniega su solicitud, usted tiene derecho a que la denegación sea revisada por un profesional de la salud autorizado que no haya participado de forma directa en la denegación de su solicitud, y el DHS cumplirá con el resultado de la revisión.

Derecho a una copia electrónica de los registros médicos electrónicos. Si su Información Médica se mantiene en formato electrónico (conocido como expediente médico electrónico o historia clínica electrónica), tiene derecho a solicitar que se le entregue una copia electrónica de su expediente o que se transmita a otra persona o entidad. El DHS hará todo lo posible para proporcionar acceso a su Información Médica en la forma o formato que usted solicite, si es que se puede producir con facilidad en dicha forma o formato. Si la Información Médica no puede producirse con facilidad en la forma o el formato que usted solicita, su registro se proporcionará en nuestro formato electrónico estándar. Si no desea esta forma o formato, se le facilitará una copia impresa legible. El DHS puede cobrarle una tarifa razonable basada en el costo por la mano de obra asociada a la transmisión de la historia clínica electrónica.

Derecho a ser notificado de una infracción. Tiene derecho a ser notificado en caso de que se produzca una infracción respecto a su Información Médica Protegida no asegurada.

Derecho de enmienda. Si cree que el DHS tiene información incorrecta o incompleta sobre usted, puede solicitar al DHS que modifique la información. Tiene derecho a solicitar una modificación mientras la información se conserve en nuestra oficina o para ella. Para realizar cambios, puede acceder a su portal de usuario, ponerse en contacto con el servicio de atención al cliente del programa solicitado, ponerse en contacto con el gestor de su caso o realizar su solicitud, por escrito, al Oficial de Privacidad mencionado a continuación. Le recomendamos que revise su información de forma regular para asegurarse de que es correcta.

Derecho a un recuento de las divulgaciones. Usted tiene el derecho de solicitar una lista de ciertas divulgaciones que el DHS hizo de Información Médica para propósitos diferentes al tratamiento, pago y operaciones de atención médica o para las cuales usted proporcionó una autorización por escrito. Para solicitar un recuento de las divulgaciones, debe presentar su solicitud, por escrito, al Oficial de Privacidad.

Derecho a solicitar restricciones. Tiene derecho a solicitar una restricción o limitación de la Información Médica que el DHS utiliza o divulga para el tratamiento, el pago o las operaciones de atención médica. También tiene derecho a solicitar que se limite la información médica que el DHS divulga a alguien que participe en su cuidado o en el pago de su atención, como un familiar o amigo. Por ejemplo, puede pedir que el DHS no comparta información sobre un determinado diagnóstico o tratamiento con su cónyuge. Para solicitar una restricción, debe hacer su petición, por escrito, al Oficial de Privacidad. El DHS no está obligado a aceptar su petición a menos que usted solicite que el DHS restrinja el uso y la divulgación de su Información Médica a un plan de salud con fines de pago o de operación de atención médica y dicha información que usted desea restringir se refiera únicamente a un artículo o servicio de atención médica por el que usted haya pagado "de su bolsillo" en su totalidad. Si el DHS está de acuerdo, aceptaremos su solicitud a menos que la información sea necesaria para proporcionarle un tratamiento de emergencia.

Derecho a solicitar comunicaciones confidenciales. Tiene derecho a solicitar que el DHS se comunique con usted sobre asuntos médicos de una manera determinada o en un lugar concreto. Por ejemplo, puede pedir que el DHS sólo se ponga en contacto con usted por correo o en su trabajo. Para solicitar comunicaciones confidenciales, debe hacer su petición, por escrito, al Oficial de Privacidad. Su solicitud debe especificar cómo o dónde desea ser contactado. El DHS tendrá en cuenta las solicitudes razonables.

Derecho a una copia en papel de este aviso. Tiene derecho a recibir una copia en papel de este aviso. Puede solicitar una copia de este aviso en cualquier momento. Aunque haya aceptado recibir este aviso por vía electrónica, tiene derecho a recibir una copia en papel de este aviso. Para obtener una copia en papel de este aviso, póngase en contacto con el Oficial 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

PROTECCIONES:

El DHS se compromete a proteger su información personal. La PII y la Información Médica Protegida (PHI, en inglés) están protegidas con salvaguardas operativas, administrativas, técnicas y físicas razonables para garantizar su confidencialidad, integridad y disponibilidad y para evitar el acceso, uso y/o divulgación no autorizados de la información protegida. No vendemos ninguna información que se nos facilite. Nos adherimos de forma estricta a una serie de normas federales y estatales relacionadas con la privacidad y la seguridad de la información, diseñadas para mantener su información segura.

CAMBIOS EN ESTE AVISO:

El DHS se reserva el derecho de modificar este aviso en cualquier momento. El nuevo aviso se aplica a la información ya obtenida, así como a cualquier información recibida en el futuro. El DHS publicará una copia del aviso actual en nuestra oficina y en el sitio web https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel. El aviso contendrá la fecha de entrada en vigor en la primera página, en la esquina superior derecha.

RECLAMOS:

Si tiene alguna pregunta sobre este aviso, póngase en contacto con:

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

Si cree que se han violado sus derechos de privacidad, puede presentar un reclamo por escrito si se pone en contacto con el Oficial de Privacidad mencionado anteriormente. Incluya su nombre, número de teléfono, número de caso y una descripción del reclamo. **No se le sancionará por presentar un reclamo.**

También puede presentar su reclamo ante la Oficina de Derechos Civiles (OCR, en inglés) del Departamento de Salud y Servicios Humanos de los Estados Unidos. Para obtener más información sobre los requisitos de privacidad de la Ley de Portabilidad y Responsabilidad de los Seguros de Salud (HIPAA, en inglés), las transacciones electrónicas de la Ley HIPAA y la normativa sobre conjuntos de códigos, así como las normas de seguridad de la Ley HIPAA propuestas, visite el sitio web de los Estados Unidos. Sitio web del Departamento de Salud y Servicios Humanos en: https://www.hhs.gov/hipaa/index.html.

Si tiene preguntas sobre su salud o sus servicios de atención médica, debe ponerse en contacto con su proveedor de atención médica (médico, farmacia, hospital u otro proveedor médico).

CONSENTIMIENTO:

Al enviarnos su información personal, usted acepta que podamos recopilar, utilizar y divulgar dicha información según lo permita o exija la ley.

[A CONTINUACIÓN, LA PÁGINA DE FIRMAS]

Página de firmas

Si desea acusar recibo de este aviso de prácticas de privacidad del DHS, firme a continuación y envíe esta página a la dirección indicada más abajo.

He leído, entiendo y acuso recibo del aviso de prácticas de privacidad del DHS.

_____ _____

Firma Fecha

_____

Nombre en letra de imprenta

Dirección para la devolución:

[Insertar aquí la dirección local]

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

PURPOSE

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

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

PREPARATION

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

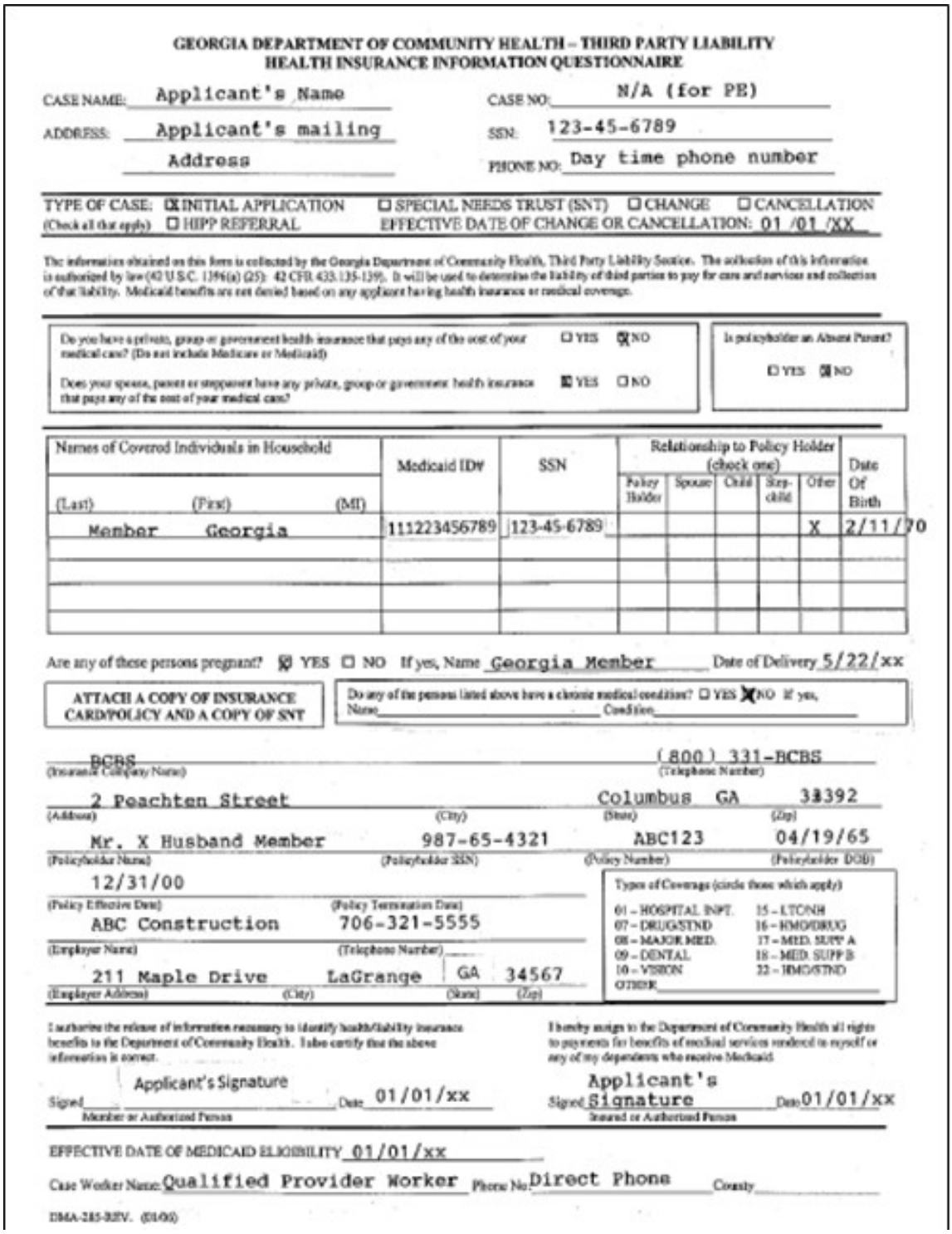
Health Management System (HMS)
900 Circle 75 Parkway
Suite 650
Atlanta, GA 30339
OR
Fax: 770-937-0180

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

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

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

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

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

CASE NAME:_____ CASE NO:_____

ADDRESS: _____ SSN: _____

_____ PHONE NO:_____

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

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

Do you have a private, group or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) ☐ YES ☐ NO

Does your spouse, parent or stepparent have any private, group or government health insurance that pays any of the cost of your medical care? ☐ YES ☐ NO

Is policyholder an Absent Parent? ☐ YES ☐ NO

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

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

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

Do any of the persons listed above have a chronic medical condition? ☐ YES ☐ NO If yes, Name_____ Condition_____

_____ (_____)_____
(Insurance Company Name) (Telephone Number)

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

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

_____
(Policy Effective Date) (Policy Termination Date)

_____
(Employer Name) (Telephone Number)

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

Types of Coverage (circle those which apply)

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

OTHER_____

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

Signed_____ Date_____
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_____ Date_____
Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY_____

Case Worker Name:_____ Phone No:_____ County_____

DMA-285-REV. (01/06)

Quick Guide on PE Medical Assistance

This document is for informational purposes, only. For applicants, who apply for PE Medical Assistance with Qualified Hospitals, it explains to them what to expect if their application is approved for the program. QH should give this document to the applicant, along with other forms required, as part of the application process.

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

Quick Guide on Presumptive Eligibility Medical Assistance

Presumptive Eligibility (PE) is temporary Medical Assistance. PE Medical Assistance covers related Medical Assistance services except inpatient hospital stay and delivery services.

If you applied for ongoing and/or retroactive Medical Assistance, your application is being sent to the Division of Family and Children Services (DFCS) office for a final eligibility determination. A DFCS Medical Assistance Specialist may contact you for additional information.

You will receive a letter in the mail letting you know if your application for ongoing and/or retroactive Medical Assistance was approved or denied.

You must report **all** household changes within 10 days. You can report the changes by calling **1- 877-423-4746** or online at www.gateway.ga.gov.

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

Note: Former Foster Care Medical Assistance beneficiaries are auto assigned to Amerigroup as your CMO.

You will have a yearly renewal.

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

If you have questions about what Medical Assistance covers, ask your doctor or call:**1-866-211-0950.**

Revised 7/28/21

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

Guía Rápida sobre Presunta Elegibilidad Asistencia Médica

Presunta Elegibilidad (PE) es Asistencia médica temporal. PE Asistencia Médica cubre los servicios de asistencia médica relacionados, excepto los servicios de estadía hospitalaria para pacientes internados y servicios de parto.

Si solicitó la admisión y / o la Asistencia médica retroactiva, la División de Servicios Familiares y de los Niños (DFCS) enviarán su solicitud a la Derecha para una determinación final de elegibilidad. Un especialista en asistencia médica de DFCS puede contactarlo para obtener información adicional.

Recibirá una carta por correo que le informará si su solicitud de inscripción y / o asistencia médica retroactive fue aprobada o denegada.

Usted debe informar **todos** los cambios en el hogar dentro de 10 días. Puede informar los cambios llamando **1-877-423-4746** o en línea en gateway.ga.gov.

Poco después de ser elegible para recibir Asistencia Médica completa, se inscribirá en unade las tres Organizaciones de Administración de Atención (CMO): Amerigroup, CareSource o PeachState. Si desea cambiar su CMO, tendrá 90 días para hacerlo. Puede cambiar su CMO, comunicándose con Georgia Families por teléfono al **1-888-423-6765**, en línea en www.georgia-families.com, por correo o fax.
Nota: Antigua asistencia médica de cuidado de crianza los miembros se asignan automáticamente a Amerigroup como su CMO.

Tendrás una renovación anual.

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

Si tiene preguntas sobre lo que cubre la Asistencia Médica , consulte a su médico o llame al: **1-866-211-0950**.

Revisado el 7/28/21

Presumptive Eligibility Manual Updates

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

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

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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

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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

CONFIDENTIALITY PROVISION

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

Revised 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:	

CONFIDENTIALITY PROVISION

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Revised 7/28/21

Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance.

The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at 404-657-3433 or DCH at 678-248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form at the DCH Katie Beckett (KB) Team office or online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, but you do not have to use a form.

How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street N.W., Ste 19-454, Atlanta, GA, 30303, 404-657-3735. For DCH, contact the KB TEAM ADA/Section 504 Coordinator at: 2211 Beaver Ruin Road, Suite 150, Norcross, GA 30071 or P.O. Box 172 Norcross, GA. 30091, 678-248-7449.

You can ask your case worker for a copy of the DFCS civil rights complaint form. The complaint form is also available at https://dfcs.georgia.gov/adasection-504-and-civil-rights. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the "USDA-HHS Joint Nondiscrimination Statement" included within.

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

Revised 12/09/2020

Aviso de derechos según la Ley de Estadounidenses con Discapacidades (ADA)/sección 504

Ayuda para personas con discapacidad

La ley federal* exige que el Departamento de Servicios Humanos de Georgia y el Departamento de Salud Comunitaria de Georgia ("los Departamentos") brinden a las personas con discapacidad la misma oportunidad de participar y reunir los requisitos para los programas, los servicios o las actividades de los Departamentos. Esto incluye programas como SNAP (Programa de Asistencia Nutricional Suplementaria), TANF (Asistencia Temporal para Familias Necesitadas) y Asistencia Médica.

Los Departamentos brindan modificaciones razonables cuando son necesarias para evitar la discriminación basada en la discapacidad. Por ejemplo, podemos cambiar políticas, prácticas o procedimientos para brindar acceso equitativo. Para garantizar una comunicación igualmente efectiva, brindamos asistencia de comunicación a las personas con discapacidad o sus acompañantes con discapacidad, como intérpretes de lengua de señas. Nuestra ayuda es gratis. Los Departamentos no están obligados a realizar ninguna modificación que resulte en una alteración fundamental en la naturaleza de un servicio, un programa o una actividad o en cargas financieras y administrativas indebidas.

Cómo solicitar una modificación razonable o asistencia de comunicación

Comuníquese con su asistente social si tiene una discapacidad y necesita una modificación razonable, asistencia de comunicación o ayuda adicional. Por ejemplo, llame si necesita ayuda o servicio para una comunicación efectiva, como un intérprete de lengua de señas. Puede comunicarse con su asistente social o llamar al DFCS (Departamento de Servicios para la Familia y los Niños) al 404-657-3433 o al DCH (Departamento de Salud Comunitaria) al 678-248-7449 para hacer su solicitud. También puede realizar su solicitud utilizando el formulario del DFCS para solicitud de modificación razonable en virtud de la ADA (Ley para Estadounidenses con Discapacidades), que está disponible en la oficina local del DFCS o en línea en https://dfcs.georgia.gov/adasection-504-and-civil-rights. Además, puede obtener el formulario del DCH para solicitud de modificación razonable en virtud de la ADA en la oficina del equipo Katie Beckett (KB) del DCH o en línea en https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, pero no es necesario usar un formulario.

Cómo presentar una queja

Tiene derecho a presentar una queja si los Departamentos lo han discriminado por su discapacidad. Por ejemplo, puede presentar una queja por discriminación si ha solicitado una modificación razonable o un intérprete de lengua de señas que se le hayan negado o que no se hayan resuelto en un plazo razonable. Puede presentar una queja verbalmente o por escrito comunicándose con su asistente social, la oficina local del DFCS o el coordinador de derechos civiles y de la ADA/Sección 504 del DFCS en 2 Peachtree Street N.W., Ste 19-454, Atlanta, GA, 30303, 404-657-3735. Para el DCH, comuníquese con el coordinador del equipo KB y la ADA/Sección 504 en 2211 Beaver Ruin Road, Suite 150, Norcross, GA, 30071, o P.O. Box 172, Norcross, GA 30091, 678-248-7449.

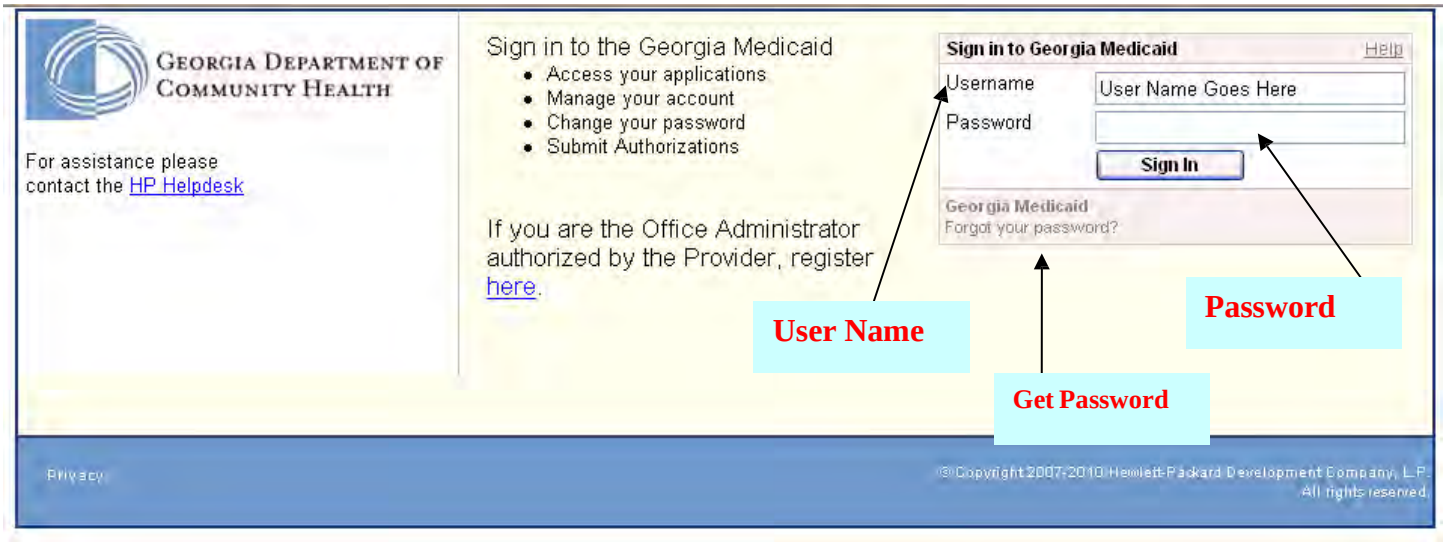
Puede pedirle a su asistente social una copia del formulario de queja de derechos civiles del DFCS. El formulario de queja también está disponible en: https://dfcs.georgia.gov/adasection-504-and-civil-rights. Si necesita ayuda para presentar una queja por discriminación, puede comunicarse con el personal del DFCS mencionado anteriormente. Las personas sordas o con problemas de audición, o que tengan discapacidades del habla, pueden llamar al 711 para que un operador se conecte con nosotros.

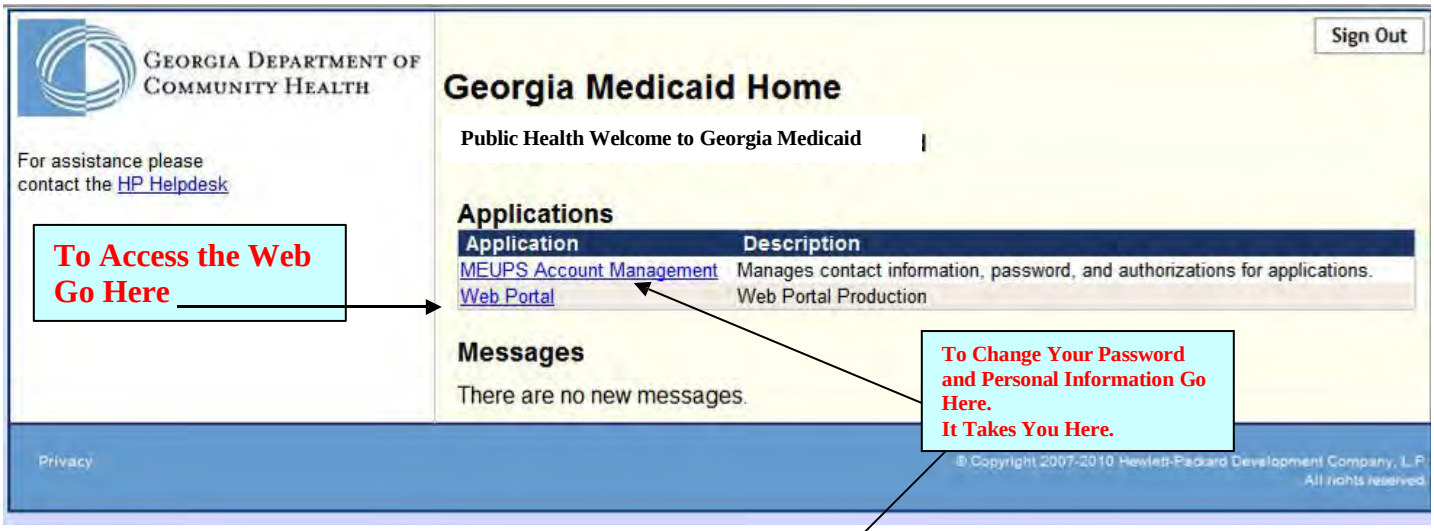
También puede presentar una queja por discriminación ante la agencia federal correspondiente. La información de contacto del Departamento de Agricultura de los EE. UU. (USDA) y del Departamento de Salud y Servicios Humanos de los EE. UU. (HHS) se encuentra dentro de la "Declaración conjunta de no discriminación del USDA-HHS" incluida.

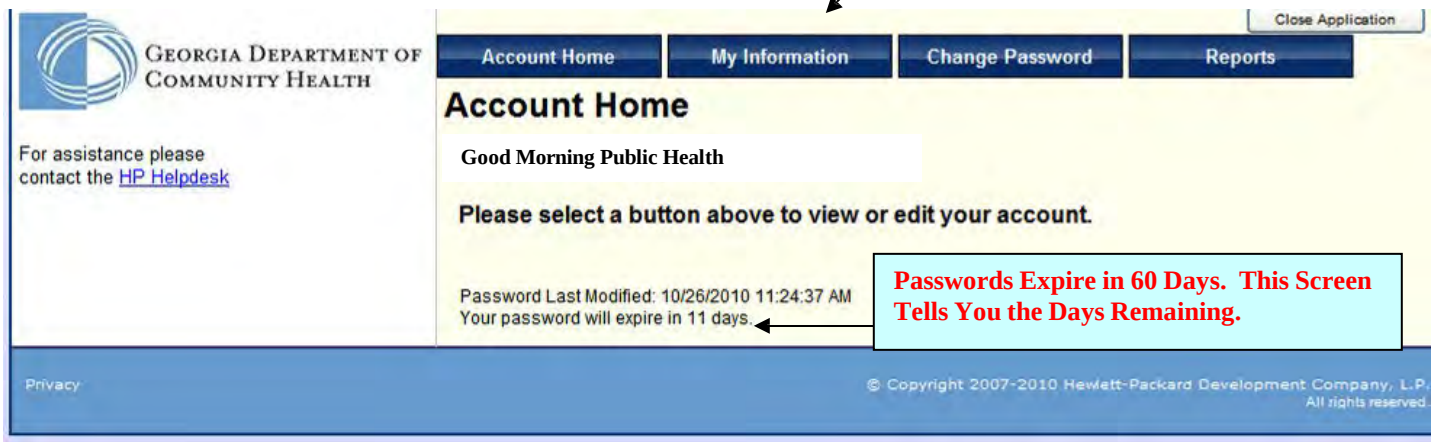
09/dic/20

APPENDIX G – GAMMIS

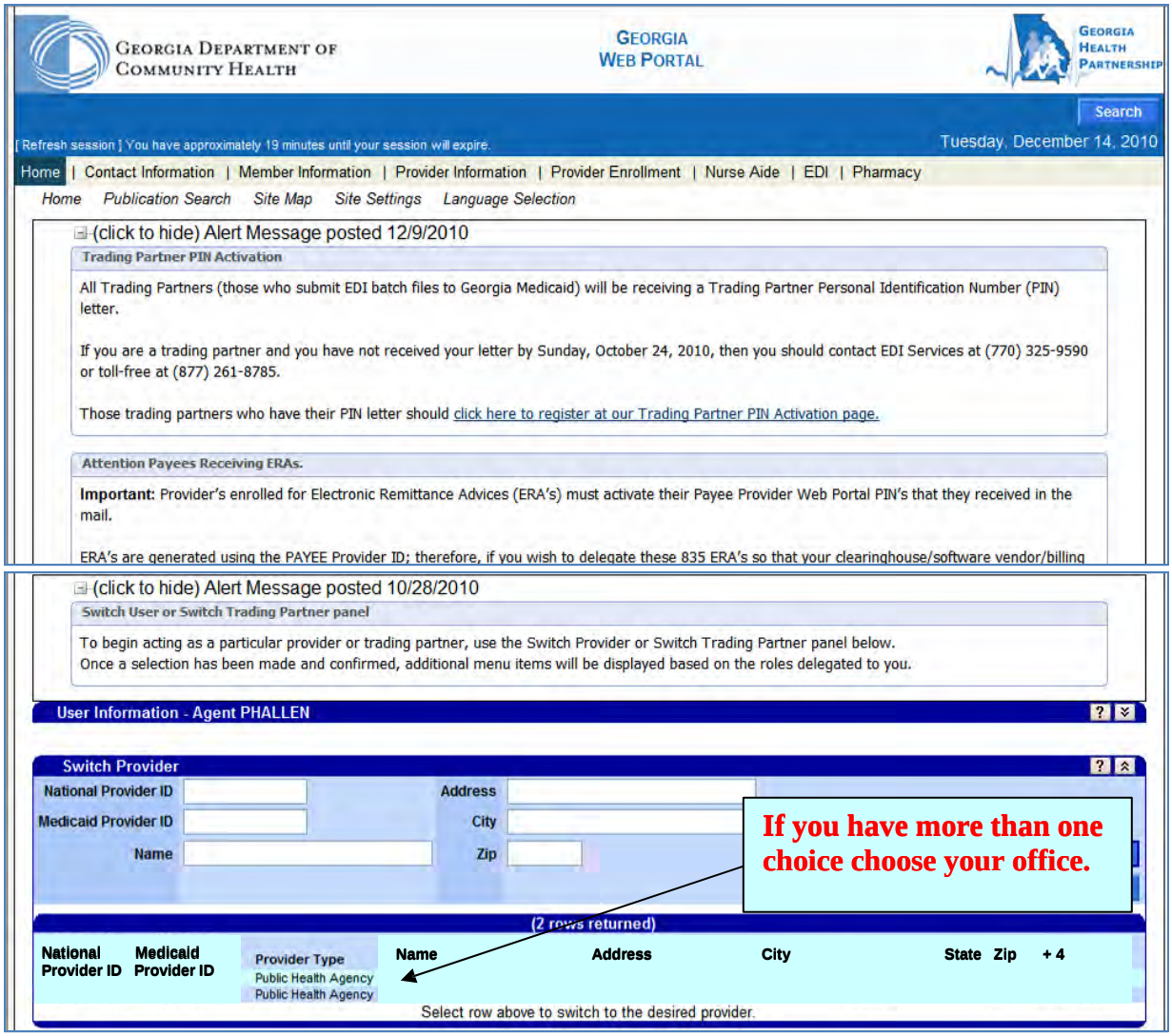
Sign on to GAMMIS:







Going to the Web:

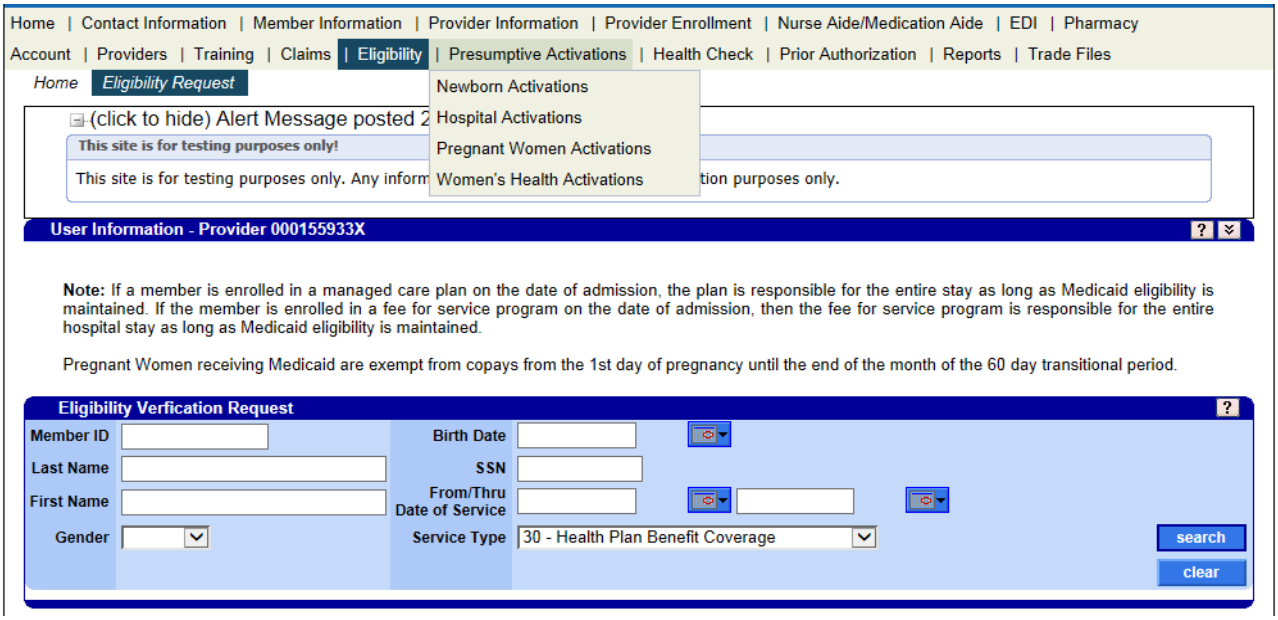


Messages:

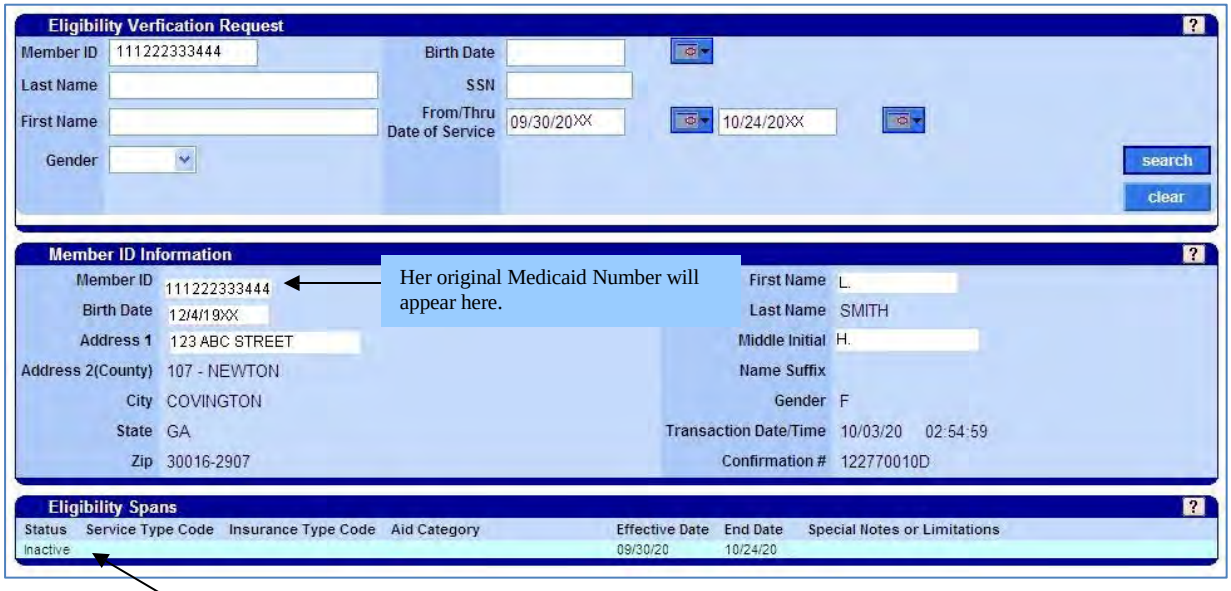


Screening on the web portal:

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



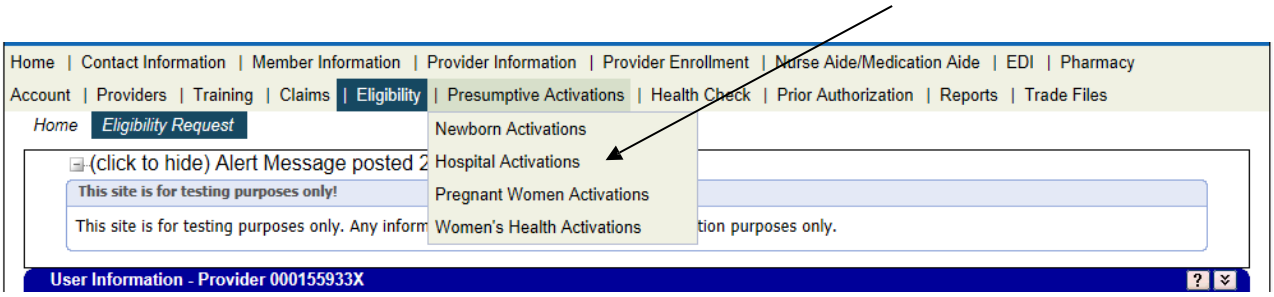
If the applicant was ever known to the system, you will see them as inactive at the bottom of the screen.



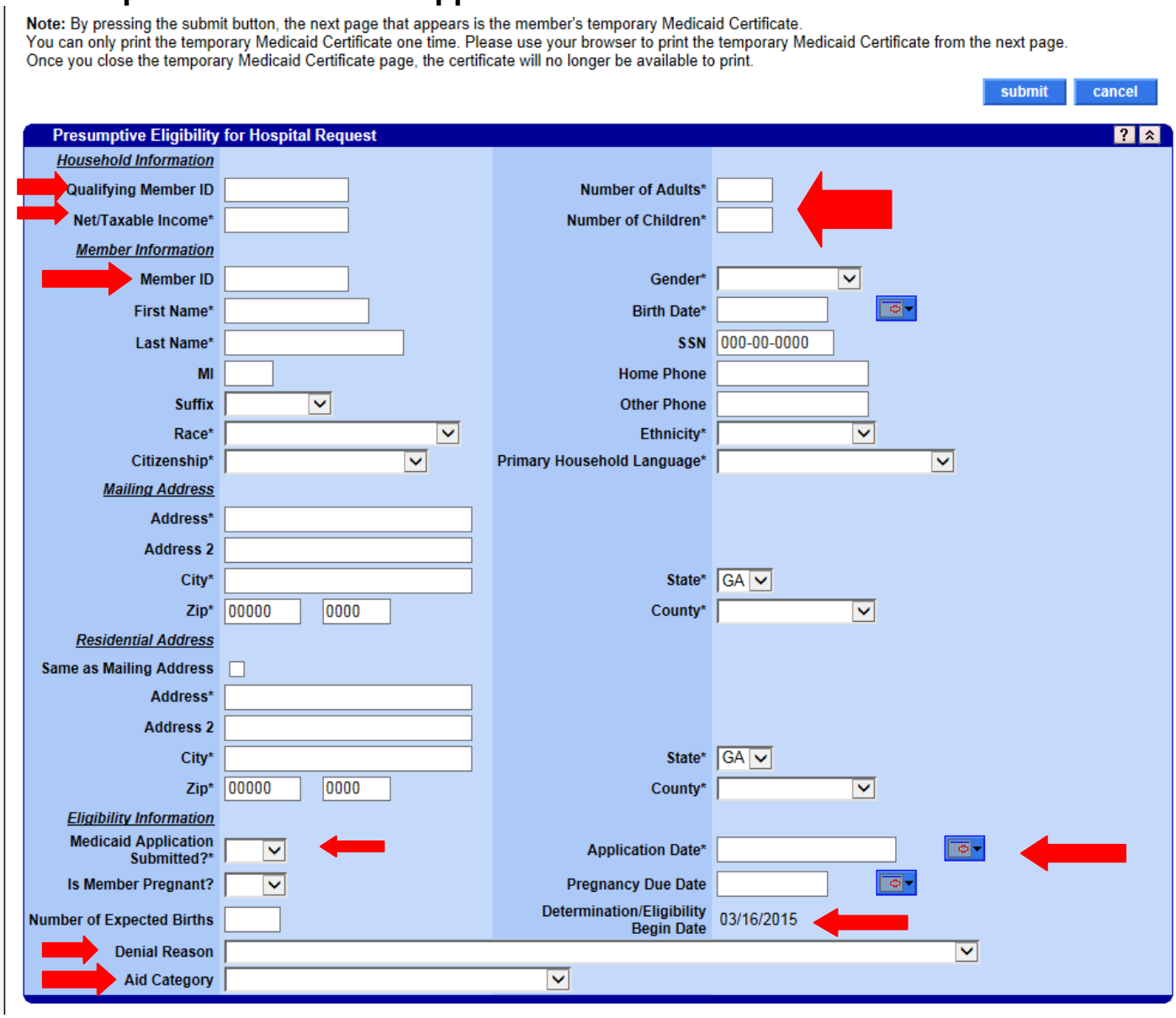
If they have never had Medical Assistance this screen will not appear.

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

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:

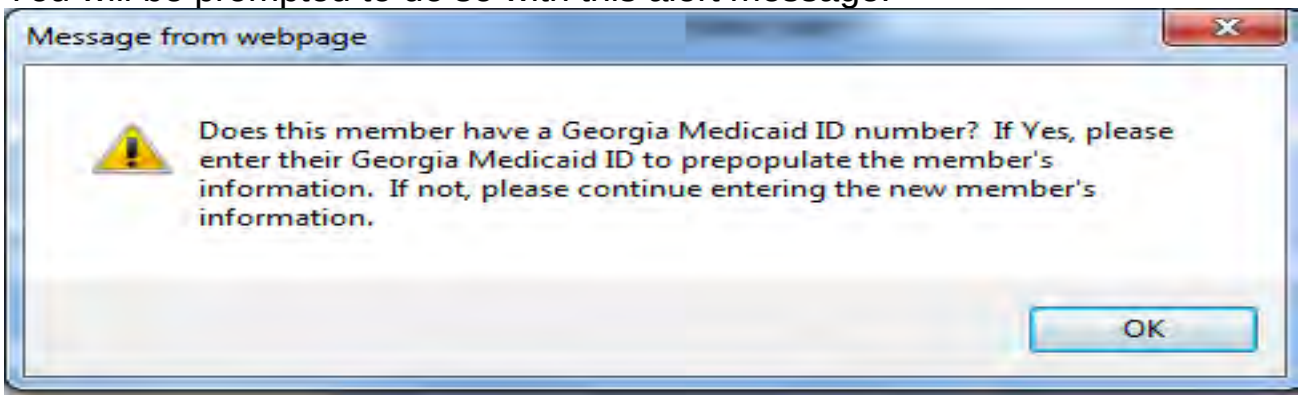


The Hospital PE Screen will appear:



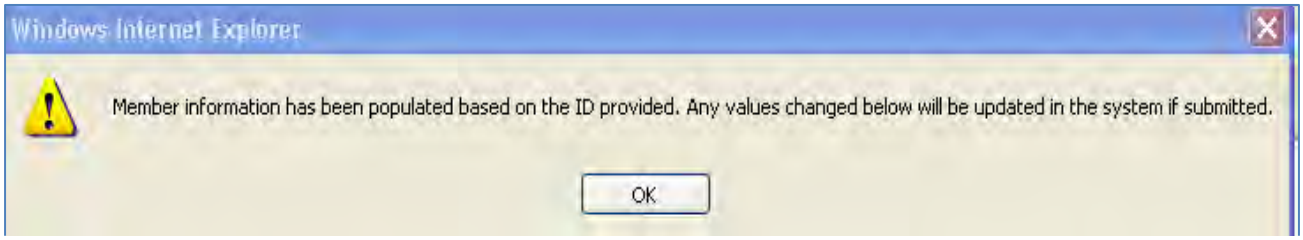
Enter the applicant's original ID number to auto-populate the fields on this panel.

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

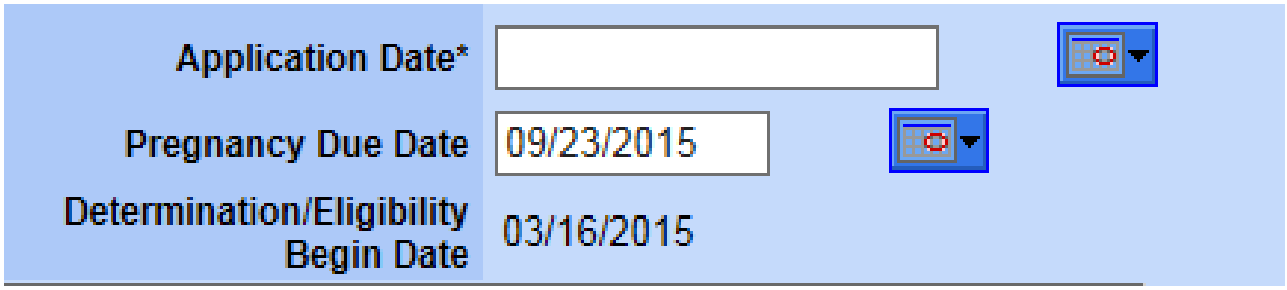


All information can be changed except the First Name, Date of Birth (DOB) and Social Security Number (SSN). If this information needs to be corrected use the current PE Corrections Coversheet procedure after you enter the PE in the Web.

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



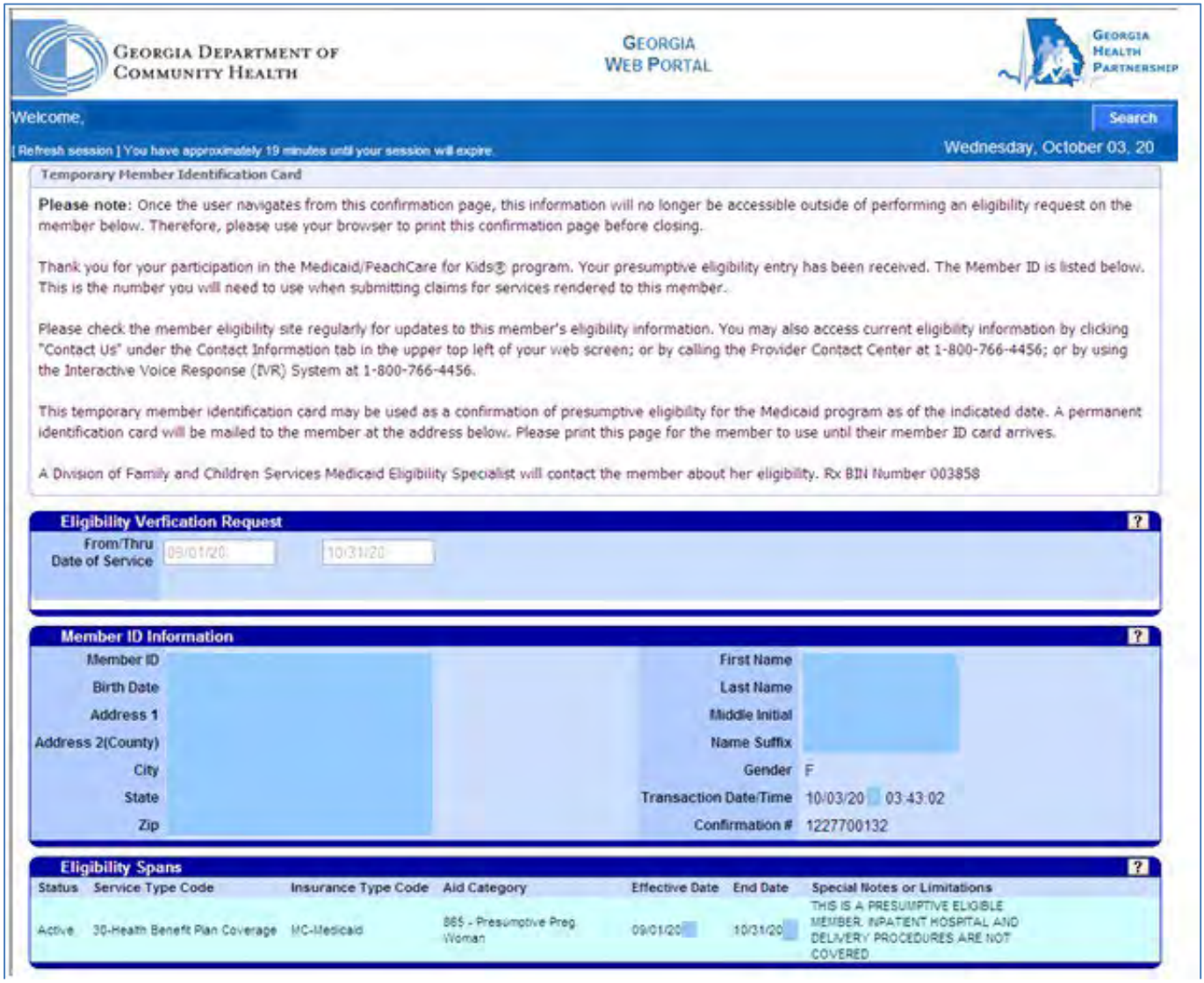
The applicant's last known information in GAMMIS will auto-populate. The Determination/Eligibility Begin Date field will pre-populate with today's date. This field cannot be modified.



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



Appendix I – Income

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

2499 – TREATMENT OF INCOME IN MEDICAL ASSISTANCE

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

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

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
ADOPTION ASSISTANCE	Unearned – Payment received for the adoption of certain children.	E (MAGI and Non MAGI)	E
IV-E	Exclude as income.	E (MAGI and Non MAGI)	E
IV-B	Exclude as income.		
ADVANCE	Unearned – Money for future expenses that does not represent a gain to the AU.	E(MAGI and Non MAGI)	E
	Earned – A prepayment of wages or salaries.	I (MAGI and Non MAGI)	I
AGENT ORANGE PAYMENTS	Unearned – A payment made to a Vietnam Veteran who was exposed to Agent Orange defoliant. The payment is made to the surviving spouse and children.	E (MAGI and Non MAGI)	I
ALASKA NATIVE CLAIM	Unearned – Payments made under Alaska Native Claims Settlement Act.	E (MAGI and Non MAGI)	I
	Alaska Permanent Fund Dividend-payment from Alaska's mineral income fund.	I (MAGI and Non MAGI)	I
ALIMONY/ SPOUSAL SUPPORT	Unearned – A court-ordered payment from an estranged spouse or former spouse to the other spouse for support under the terms of a court order or settlement agreement following a divorce. Payments may be in one lump sum, or in a series of monthly payments. Alimony is also termed "spousal support" or "maintenance".	I (Non MAGI) E* (MAGI) *Divorces and separations finalized/ modified before 1/1/2019, include Alimony as income for MAGI.	I
AMERICORPS	Income from Americorps Network of programs which encompasses: Americorps USA Americorps VISTA Americorps NCCC Are handled as specified below:		

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
CENSUS INCOME	Earned- All wages paid by the Census Bureau for temporary employment related to Census activities.	E (Non MAGI) I* (MAGI) *As of 1/1/2019	E
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATION NOT STATE/ FEDERALLY FUNDED	Unearned – Charitable donation paid to the AU or BG.	E (MAGI and Non MAGI)	E
CHARITABLE DONATION FROM FEDERALLY OR STATE FUNDED ORGANIZATION	Unearned – Charitable donation paid to the AU or BG from organizations receiving state or federal funds. For example: Salvation Army, United Way, Catholic Charities, and Lutheran Social Service Agencies.	I (MAGI and Non MAGI)	I
CHILD CARE ATTENDENT (wages earned by)	Earned – income received for providing child care services. Consider the income as follows: • Self-employment if the attendant provides child care services in his/her home As wages if the attendant provides services in the home of the child.	I (MAGI and Non MAGI)	I
CHILD CARE PAYMENTS	Unearned – Payments made under Title IV of the Social Security Act to a child care provider on behalf of the AU. These payments include Transitional Child Care, and At Risk block grant child care payments made under P.L. 101-508, Section 5801 of the Social Security Act.	E (MAGI and Non MAGI)	E
CHILD NUTRITION PAYMENTS	Unearned – The value of meals provided to a child in day care through the Child Nutrition Amendment of 1978.	*I (MAGI and Non MAGI)	I

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
	• Cash or in-kind gifts given by relatives, friends, or a community group to "help out" with expenses related to the death • Inheritances in cash or in kind • Lump sum death benefits from SSA • Proceeds of life insurance policies received due to the death of the insured • RR Retirement burial benefits • VA burial benefits NOTE: Recurring survivor benefits such as those received under Title II (RSDI), private pension programs, etc., are not death benefits. * Death benefits provided to an individual are income to the individual to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the individual. Last illness and burial expenses include related hospital and medical expenses, funeral, burial plot, and interment expenses; and other related expenses. Verify all last illness and burial expenses. If verification (e.g., bills, receipts, contact with provider, etc.) cannot be obtained, accept the individual's signed allegation. If an expense has been incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No follow-up is required if the assumption is applied. Use judgment to determine whether an expense is reasonably related to the last illness and burial. It is expected that related expenses may include such items as new clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc.		

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

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

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

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

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

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
(FMHA) UTILITY REIMBURSEMENT	Payments can be paid directly to the AU, by a two-party check or directly to the utility company on behalf of the AU.		
INCOME BASED ON NEED (IBON)	Unearned – Assistance provided under a program that considers other income as a factor in determining eligibility and is funded wholly or partially by the federal government or a non-governmental agency for the purpose of meeting basic needs (TANF, SSI, VA Pension, etc.). Continued next page.	See specific type of IBON	See specific type of IBON
INCOME BASED ON NEED (IBON) (cont.)	NOTE FOR ABD: Do not allow the $20 general exclusion to IBON. Do not deem IBON received by the A/R's spouse or parent to the A/R.		
INCOME TAX REFUND	*Refer to the Chapter 3300, Resources, to determine how to count income tax refunds. For how to count in PL/CS, refer to Section 2552, PL/CS Deductions.	*	*
INDIAN LAND GRANTS	Unearned – Federal distributions to members of Indian Tribes.	E	E
INDIAN GAMBLING ACT PAYMENTS	Tribally managed gaming revenues * If the funds have NOT been held in trust by the Secretary of the Interior, count as unearned income. If held in trust by the Sec. of Interior, exclude.	*	*
INHERITANCE	Unearned– cash, a right or non-cash item(s) received as a result of someone's death. Exclude expenses for the last illness & burial of the deceased if paid by the inheritor. NOTE: Until an item or right has a value or is accessible, it is neither income nor a resource.	I	I

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE

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

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

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

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

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE

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

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE

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

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

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

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

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

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

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

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

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

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE			
TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY-FAMILY OR ABD	PL/CS FOR ABD
	• The payment is a set monthly amount based on a court ruling. Count as income in the month of receipt.	I	I
VISTA VOLUNTEER PAYMENT	Earned – Income received by VISTA volunteers under Title I of the Domestic Volunteer Services Act. Included are payments from the Urban Crime Prevention Program	E	E
VOLUNTEER PAYMENT RSVP Foster Grandparent/ VISTA Urban Crime Prevention	Unearned – Title II of Domestic Volunteer Services Act of 1973 Unearned – Payments from Title I. Exclude only if the A/R was receiving FS or AFDC at the time they joined Title I even if there is a break in participation.	E E	I I
WAGES (SALARIES) Children in Placement	Earned – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis. Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee's share of FICA when paid by the employer. Reference Section 2835, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria.	I	I
WORKER'S COMPENSATION	Unearned – payments awarded to injured employees or to their survivors. Exclude any portion designated for medical, legal, or related expenses paid or deducted and not controlled by the A/R in connection with claim. Verify from the employer or from the source of the payment.	ABD-I FM-E	I
WORKFORCE INVESTMENT ACT	Earned – Income received while working as part of a WIA program.	I	I

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

APPENDIX M
MEMOS

Date	Title
2/20/15	Presumptive Eligibility Medicaid Federal Poverty Levels for 2015
3/4/15	GAMMIS System changes for Presumptive PGW and Presumptive WHM
7/9/15	Same Sex Marriage-Income/Resources
3/11/16	Presumptive Eligibility Medicaid Federal Poverty Levels for 2016
8/21/14	RSDI Income of Tax Dependents for MAGI based Medicaid and PeachCare for Kids determinations
7/7/16	Clarification: 5% MAGI FPL deduction
2/20/17	Presumptive Eligibility Medicaid Federal Poverty Levels for 2017
2/19/18	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2018
9/11/18	Clarification of Declaration of Citizenship/Immigration Status
10/24/18	Dependent Tax Filing Threshold
2/20/19	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2019
9/24/19	Tax Cuts and Jobs Act of 2017/Bipartisan Budget Act of 2018
2/19/20	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2020
2/19/21	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2021
7/16/21	Compact of Free Association (COFA) Migrants
2/14/22	Retention of Presumptive Eligibility Application Packets
2/18/22	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2022

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

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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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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July 9, 2015

MEMORANDUM

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

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

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

Question:

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

Response:

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

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

Please note we do not count resources in MAGI.

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

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

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MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2016

DATE: March 11, 2016

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

1	310	50	360	1317	1367	1476	1526	2030	2080	2178	2228	2446	2496	1980	2030
2	457	67	524	1776	1843	1990	2057	2737	2804	2937	3004	3298	3365	2670	2737
3	551	84	635	2235	2319	2504	2588	3444	3528	3696	3780	4150	4234	3360	3444
4	653	102	755	2694	2796	3018	3120	4152	4254	4455	4557	5002	5104	4050	4152
5	752	119	871	3153	3272	3532	3651	4859	4978	5214	5333	5854	5973	4740	4859
6	826	136	962	3611	3747	4046	4182	5566	5702	5973	6109	6707	6843	5430	5566
7	903	154	1057	4072	4226	4561	4715	6276	6430	6735	6889	7561	7715	6122	6276
8	970	171	1141	4539	4704	5078	5249	6987	7158	7498	7669	8418	8589	6816	6987
9	1034	188	1222	4995	5183	5595	5783	7698	7886	8262	8450	9275	9463	7510	7698
10	1113	206	1319	5455	5661	6111	6317	8408	8614	9023	9229	10,130	10,336	8202	8408
11	1194	223	1417	5916	6139	6628	6851	9119	9342	9786	10,009	10,987	11,193	8896	9119
12	1244	240	1484	6378	6618	7145	7385	9830	10,070	10,550	10,790	11,844	12,084	9590	9830

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

Budget Group	200% FPL
1	1980
2	2670
3	3360
4	4050
5	4740
6	5430
7	6122
8	6816
9	7510
10	8202
11	8896
12	9590

Add $694 to the net income limit for any additional individual(s) added.

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

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

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August 21, 2014

MEMORANDUM

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

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

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

BACKGROUND

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

PURPOSE

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

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

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

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

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

Note: RSDI does NOT count toward the unearned threshold.

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

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

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

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Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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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 7, 2016

RE: Clarification: 5% MAGI FPL deduction

DCH understands that the SUCCESS system is not currently programmed to correctly apply the 5% Modified Adjusted Gross Income (MAGI) Federal Poverty Level (FPL) deduction. Application of this deduction will be corrected with the implementation of the new Georgia Integrated Eligibility System, Georgia Gateway. This policy memo is to align policy correctly so that staff are trained appropriately in preparation for IES implementation.

This memo will provide clarification of the application of the 5% MAGI FPL deduction in the MAGI budget when determining eligibility for Medical Assistance benefits.

Section 2669-MAGI Budgeting in the Office of Family Independence Medicaid manual, states that a tax filer budget group's net taxable income is determined by deducting the following from the Budget Group's (BG) gross income:

- Cost of doing business for self-employed or farming/fishing individuals.
- Before-Tax deductions
- 1040 deductions
- MAGI 5% FPL deduction

The net taxable income is then compared against the FPL for the BG size to determine eligibility for Medical Assistance categories.

This memo clarifies that the MAGI 5% deduction is NOT applied at this point, but that Net Taxable income is determined by deducting the cost of doing business for self-employed or farming/fishing individuals; before-Tax deductions; or any 1040 deductions and THEN compared against the FPL for the BG size. If the BG's Net Taxable income puts the individuals requesting assistance over the income limit for MAGI Medical Assistance, then the 5% deduction is applied only if it will bring the BG under the income limit. If the MAGI household would NOT be eligible with the 5% deduction for MAGI Medicaid continue the Medical Assistance eligibility determination for the children with PeachCare for Kids® or Medically Needy Medicaid.

Procedures beginning on Section 2669-1 should be revised to read as in the enclosure.

Please update the Office of Family Independence Medicaid manual and notify field staff of the clarification of the 5% MAGI FPL deduction prior to pilot of Georgia Gateway. Please contact Yvonne Greene at 404-463-2135 or ygreene@dch.ga.gov or Jonathan Duttweiler at 404-651-9981 or jduttweiler@dch.ga.gov if you have additional questions.

Enclosure (2 pages)

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

PROCEDURES	Follow the steps below to determine eligibility for MAGI COAs.
Step 1	Deduct any pre-tax deductions to determine the Modified Adjusted Gross Income of the BG.
Step 2	For self employed individuals, deduct all allowable IRS deductions. Refer to Section 2415, Self-Employment.
Step 3	Select the appropriate income limit; either the Parent/Caretaker limit, or the appropriate Pregnant Women or Children Under 19 limit using the criteria below. Refer to Appendix A2, Financial Limits for Family Medicaid. • 220% of the FPL for pregnant women and infants born to Medicaid-eligible women **NOTE:** Infants born to Medicaid-eligible mothers are considered to have met the Newborn Medicaid income limit, regardless of the budget group's income at the time of delivery. • 205% of the FPL for children, birth through the month the child reaches age one for children who are ineligible for Newborn Medicaid. • 149% of the FPL for children age one through the month in which the child turns age six.133% of the FPL for children age six through the month in which the child turns age 19. • Parent/Caretaker with Child(ren) limit for Parent/Caretaker with Child(ren) COA.

Step 4 Compare the MAGI amount to the appropriate income limit for the BG size.

- If the net countable income is less than or equal to the appropriate income level, approve the AU members for Medical Assistance
- .
- If the net countable income exceeds the appropriate income level for the BG size, proceed to Step 5.

Step 5

Subtract from the net income the MAGI 5% deduction for the appropriate 100% FPL for the household size. Please refer to Appendix A-2 for the deduction amounts for each household size.

- If the net countable income is now less than or equal to the appropriate income level, approve the AU members for the appropriate Medical Assistance category.
- If the net countable income still exceeds the appropriate income level for the BG size, the AU members are ineligible for that category of Medical Assistance.
  If ineligible for Parent/Caretaker with Child(ren), continue the eligibility determination to Children Under 19 coverage. If ineligible for Children Under 19 coverage, review for eligibility under PeachCare for Kids® (PCK or Medically Needy Medicaid.

NOTE: Because the Children Under 19 income limits vary based on the age of the child, it is possible that a child(ren) may be eligible for Medical Assistance while another child(ren) in the same BG may be ineligible. Continue the eligibility determination as indicated above for an ineligible child(ren) in a budget group.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Frank W. Berry, Commissioner

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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 20, 2017

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

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

For each additional person over Budget Group size 12:
Add $50 (Parent/Caretaker with Children under 19)
Add $462 (133% FPL)
Add $517 (149% FPL)
Add $711 (205% FPL)
Add $763 (220% FPL)

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

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

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

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

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

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OF COMMUNITY HEALTH

Nathan Deal, Governor

Frank W. Berry, Commissioner

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MEMORANDUM

TO: Carrie 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 2018

DATE: February 19, 2018

The purpose of this memorandum is to inform Qualified Hospitals (QH) 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 Qualified Hospitals effective March 1, 2018.

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	1,346	1,508	2,074	N/A
2	69	457	1,825	2,044	2,812	3,018
3	87	551	2,304	2,581	3,550	3,810
4	105	653	2,782	3,117	4,288	4,602
5	123	752	3,261	3,653	5,026	5,394
6	141	826	3,740	4,190	5,764	6,186
7	159	903	4,219	4,726	6,502	6,978
8	177	970	4,698	5,263	7,240	7,770
9	195	1,034	5,176	5,799	7,978	8,562
10	213	1,113	5,655	6,335	8,716	9,354
11	231	1,194	6,134	6,872	9,454	10,146
12	249	1,244	6,613	7,408	10,192	10,938

For each additional person over Budget Group size 12:
Add $50 (Parent/Caretaker with Children under 19)
Add $479 (133% FPL)
Add $537 (149% FPL)
Add $738 (205% FPL)
Add $792 (220% FPL)

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 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: 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
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Wesley Merritt, Quality Control Program Director 2
Sheila Alexander, Sr. Manager, Business Operations, PeachCare for Kids®
Barbara Vance, Myers and Stauffer

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Frank W. Berry, Commissioner

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MEMORANDUM

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

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

RE: Clarification to Declaration of Citizenship/Immigration Status

DATE: September 11, 2018

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

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

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

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

Please immediately inform staff of this clarification, update section 2215 of the Office of Family Independence Medicaid Manual, and submit Change Requests for any needed revisions in Georgia Gateway. If you have any questions or need additional information, contact Kunita Snead at 404-463-6234 or Kunita.snead@dch.ga.gov.

cc: Blake Fulenwider, Chief, Medical Assistance Plans
Lynette Rhodes, Associate Chief, Medical Assistance Plans
Jonathan Dunweiler, 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
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
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October 24, 2018

MEMORANDUM

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

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

RE: Dependent Tax Filing Threshold

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

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

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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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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September 24, 2019

MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager AW for AW
DCH Policy, Compliance & Operations

RE: Tax Cuts and Jobs Act of 2017/Bipartisan Budget Act of 2018

With the signing of the Tax Cuts and Jobs Act of 2017, PL 115-97, on December 22, 2017 and the Bipartisan Budget Act of 2018, PL 115-123 on February 9, 2018, the following changes are effective as of January 1, 2019.

Tax Cuts and Jobs Act of 2017, PL 115-97 changes to MAGI budgeting:

- Moving Expenses are no longer deducted for tax years 2018 through 2025, except for active duty service members of the Armed Forces
- Higher education tuition and fees for qualified education expenses are no longer deducted
- Temporary Census Bureau income is counted as income in MAGI budgets.
- Alimony is no longer considered as a deduction or income*
- Discharged Student Loan Debt is not included in income (and not counted in the MAGI-based income) of a student

Bipartisan Budget Act of 2018, PL 115-123:

- Lottery and Gambling lump sum winnings which are received in a single payment are counted as income (if less than $80,000 only count in month received, if $80,000 or more count equal amount over a period of time) **
- Notice provided to affected individuals must include, the date on which qualified winnings will no longer be counted

PL 115-97 applies changes to ABD resources, Achieving Better Life Experiences - ABLE accounts:

- Temporarily allows the designated beneficiary of an ABLE account to contribute additional monies, above the maximum annual limit, towards savings. The balance within a single ABLE account for an individual, including contributions and earnings, is an excluded resource.

*Divorces and separations finalized **before** January 1, 2019: **Include** as income and allow as a deduction. Divorces and separations finalized or modified **on or after** January 1, 2019: **Do not include** as income or a deduction.

**Winnings of $80,000 but less than $90,000 are counted as income over two months. For every additional $10,000 one month is added to the period. Total winnings are divided in equal installments. Winnings counted over multiple months, apply only to the individuals who received the winnings.

Please issue a numbered bulletin to expedite dissemination of this information to field staff and update Georgia Gateway and all applicable sections of the Office of Family Independence Medicaid Policy and Procedure manual to reflect this change. If you have any questions please contact Kunita Snead at Kunita.Snead@dch.ga.gov or 404-463-6234 or Anika Washington at awashington1@dch.ga.gov or 404-657-7262.

cc: Lynette Rhodes, Executive Director, Medical Assistance Plans
Brian Dowd, Deputy Executive Director, Policy, Compliance & Operations
Jonathan Duttweiler, Deputy Executive Director, Eligibility & Enrollment
Yvonne Greene, Policy Administration Director, Policy, Compliance & Operations
Mandy Corlee, RSM Medical Assistance Group, Interim Director
Stefanie Ashlaw, Director, PeachCare for Kids®
Melanee Payne, Medicaid Eligibility Quality Control, Manager
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Karen Salter, Myers and Stauffer

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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2020

DATE: February 19, 2020

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2020 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) 2020 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, 2020.

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	54	310	1,415	1,585	2,180	N/A
2	72	457	1,911	2,141	2,946	3,161
3	91	551	2,408	2,697	3,711	3,982
4	110	653	2,904	3,254	4,476	4,804
5	128	752	3,401	3,810	5,242	5,625
6	147	826	3,897	4,366	6,007	6,446
7	166	903	4,394	4,922	6,772	7,268
8	184	970	4,890	5,479	7,538	8,089
9	203	1,034	5,387	6,035	8,303	8,910
10	222	1,113	5,884	6,591	9,068	9,732
11	240	1,194	6,380	7,148	9,834	10,553
12	259	1,244	6,877	7,704	10,599	11,374

For each additional person over Budget Group size 12:
Add $19 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $497 (133% FPL)
Add $557 (149% FPL)
Add $766 (205% FPL)
Add $822 (220% FPL)

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

Budget Group	200% WHM
1	2,127
2	2,874
3	3,620
4	4,367
5	5,114
6	5,860
7	6,607
8	7,354
9	8,100
10	8,847
11	9,594
12	10,340

For each additional person over Budget Group size 12 add $747

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, Executive Director, Medical Assistance Plans
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Jonathan Duttweiler, Deputy Executive Director, Eligibility and Enrollment Office
Catherine Ivey, Deputy Executive Director, Service Delivery and Administration
Yvonne Greene, Policy Administration 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: Carie Summers, VP, Healthcare Financing
Georgia Hospital Association

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 Hospitals (QH) 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 Qualified Hospitals effective March 1, 2021.

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	54	310	1,428	1,600	2,201	N/A
2	73	457	1,931	2,163	2,976	3,194
3	92	551	2,434	2,727	3,752	4,026
4	111	653	2,938	3,291	4,528	4,859
5	130	752	3,441	3,855	5,303	5,691
6	149	826	3,944	4,418	6,079	6,523
7	168	903	4,447	4,982	6,854	7,356
8	187	970	4,950	5,546	7,630	8,188
9	205	1,034	5,453	6,109	8,405	9,020
10	224	1,113	5,957	6,673	9,181	9,853
11	243	1,194	6,460	7,237	9,957	10,685
12	262	1,244	6,963	7,801	10,732	11,517

For each additional person over Budget Group size 12:
Add $19 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $504 (133% FPL)
Add $564 (149% FPL)
Add $776 (205% FPL)
Add $833 (220% FPL)

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 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: 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
Karen Salter, Myers and Stauffer

GEORGIA DEPARTMENT
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TO: Bradley S. Green, Medicaid Unit Manager
DFCS Office of Family Independence

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Compact of Free Association (COFA) Migrants

DATE: July 16, 2021

The purpose of this memorandum is to provide new policy as it relates to Section 208 of the Consolidated Appropriations Act, 2021-COFA migrant Medicaid extension.

COFA Migrants Medicaid Extension

Effective December 27, 2020, section 208 of the Consolidated Appropriations Act, 2021 requires states and the District of Columbia (DC) to provide Medicaid coverage for individuals who are considered Compact of Free Association (COFA) migrants (also referred to as compact citizens).
The COFA Medicaid extension due to this legislation does not extend to PeachCare for Kids®.

COFA is an agreement between the United States and the three Pacific Islands sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, known as Freely Associated States.

Citizens of these Freely Associated States known as COFA migrants are to be considered "qualified non-citizens" and are not required to meet the 5-year waiting period required of other non-citizen immigrants.

DFCS must collect information regarding eligible immigration status on the Medical Assistance application and verify the immigration status of applicants through the SAVE program. (1137(d) of the Social Security Act; 42 CFR 435.406)

If unable to promptly verify citizenship or immigration status, Medical Assistance should be provided during a 90-day reasonable opportunity period (ROP) to applicants who attest to citizenship or have an eligible immigration status and meet all other eligibility requirements for Medical Assistance.

Until updates are made by the Federal Data Services Hub (FDSH) and the Federally Facilitated Marketplace (FFM), immigration status for COFA migrants may not be accurately provided and other established pathways should be used to verify the applicants' immigration status.

Please issue a numbered bulletin to expedite the dissemination of this information to field staff. Update Georgia Gateway and all applicable sections of the Office of Family Independence Medicaid Policy and Procedure manual to reflect this change. If you have any questions or need additional information, please contact Teresa Fair at 470-727-7207 or Teresa.Fair@dch.ga.gov.

cc: Lynnette Rhodes, Executive Director, Medical Assistance Plan
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Catherine Ivey, Deputy Executive Director, Service Delivery and Administration
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Melonie Wilson, Director, Quality Control
Stefanie Ashlaw, Director, PeachCare for Kids®
Karen Salter, Myers and Stauffer

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

MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager CRB for AW
DCH Policy, Compliance and Operations Office

RE: Retention of Presumptive Eligibility Application Packets

DATE: February 14, 2022

The purpose of this memorandum is to provide information regarding retention of Presumptive Eligibility (PE) application packets. Effective February 14, 2022, Department of Community Health (DCH) request all PE application packets completed by Qualified Hospitals (QH) be retained for a minimum of six months from the date of application. The storage of these PE application packets can be retained electronically or physically based on the hospital's policy/procedure. The electronic version of the PE application packets must be legible.

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 or Teresa Fair at 404-651-9978 or Teresa.fair@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
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager CRB for AW
DCH Policy, Compliance and Operations Office

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2022

DATE: February 18, 2022

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2022 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) 2022 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, 2022.

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	57	310	1,507	1,688	2,322	N/A
2	77	457	2,030	2,274	3,128	3,357
3	96	551	2,553	2,860	3,935	4,223
4	116	653	3,076	3,446	4,741	5,088
5	136	752	3,599	4,032	5,547	5,953
6	155	826	4,122	4,618	6,354	6,819
7	175	903	4,646	5,204	7,160	7,684
8	195	970	5,169	5,790	7,966	8,549
9	214	1,034	5,692	6,376	8,773	9,415
10	234	1,113	6,215	6,963	9,579	10,280
11	254	1,194	6,738	7,549	10,385	11,145
12	273	1,244	7,261	8,135	11,192	12,011

For each additional person over Budget Group size 12:
Add $20 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $524 (133% FPL)
Add $587 (149% FPL)
Add $807 (205% FPL)
Add $866 (220% FPL)

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

Budget Group	200% WHM
1	2,265
2	3,052
3	3,839
4	4,625
5	5,412
6	6,199
7	6,985
8	7,772
9	8,559
10	9,345
11	10,132
12	10,919

For each additional person over Budget Group size 12 add $787

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 or Teresa Fair at 470-727-7207 or Teresa.fair@dch.ga.gov.

cc: Lynnette Rhodes, Executive Director, Medical Assistance Plan
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Catherine Ivey, Deputy Executive Director, Service Delivery and Administration
Melonie Wilson, Director, Quality Control
Lynda Chapman, Attorney and Policy Manager
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Stefanie Ashlaw, Director, PeachCare for Kids®
Karen Salter, Myers and Stauffer

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

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Ukrainian Nationals

DATE: August 25, 2022

The purpose of this memorandum is to provide information as it relates to Medicaid and Peachcare for Kids ® eligibility for Ukrainian Nationals.

The U.S. Department of Homeland Security (DHS) is providing support and humanitarian relief to Ukrainians who have been displaced. Most Ukrainian nationals arriving in the United States are eligible for health coverage. Certain Ukrainian nationals are eligible for health coverage through Medicaid, Peachcare for Kids®, the Health Insurance Marketplace®, or Refugee Medical Assistance (RMA).

Ukrainian nationals who enter the United States as parolees on or between February 24, 2022, and September 30, 2023, are eligible for Medicaid or Peachcare for Kids ® to the same extent as refugees, without a five-year waiting period, if they meet all other eligibility requirements. These Ukrainian parolees are considered "qualified non-citizens" for the purposes of Medicaid and Peachcare for Kid® eligibility since they are eligible for the same benefits as refugees.

Ukrainian nationals who are paroled into the U.S. after September 30, 2023 and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and PCK to the same extent as refugees.

Ukrainians granted Temporary Protected Status (TPS), and Ukrainians who have pending applications for TPS and who have been granted employment authorization are not considered "qualified non-citizens" for purposes of Medicaid and Peachcare for Kids® eligibility, and thus are not eligible for Medicaid or Peachcare for Kids®.

Ukrainian non-citizens who do not qualify for full Medicaid benefits based on their immigration status may be eligible for Emergency Medical Assistance (EMA), if they meet all other eligibility requirements.

Please issue a numbered bulletin to expedite the dissemination of this information to field staff. Update Georgia Gateway and all applicable sections of the Office of Family Independence Medicaid Policy and Procedure manual to reflect this change. If you have any questions or need additional information, please contact Anika Washington at awashington1@dch.ga.gov.

cc: Lynnette Rhodes, Executive Director, Medical Assistance Plan
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Rebecca Dugger, Interim Deputy Executive Director, Eligibility and Enrollment Office
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Melonie Wilson, Director, Quality Control
Stefanie Ashlaw, Director, PeachCare for Kids®
Karen Salter, Myers and Stauffer

Appendix R -Resources

Georgia Families

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

It is important to note that GF is a full-risk program; this means that the 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	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.

	due to moral or religious objections • PCP moves, retires, etc.	

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

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

Planning for Healthy Babies PostCards



WHAT IS P4HB?

Planning for Healthy Babies provides no-cost family planning services to eligible Georgia residents. You may be eligible for:

- Pregnancy testing and counseling, birth control, STD screening & treatment, and annual exams (including pap smears)
- Inter-Pregnancy Care (IPC): Family planning, nurse case manager, and additional services for individuals who have delivered a baby weighing less than 3 lbs, 5 oz. Receive services for 24 months.
- Access to a Resource Mother: Specially trained case manager to provide assistance to individuals already receiving Medicaid that have delivered a baby weighing less than 3 lbs, 5 oz. Receive services for 24 months.

WHAT IS COVERED?

- Annual physical exams (including pap smears)
- Birth control and multivitamins with folic acid
- Family planning counseling
- IPC services including primary care & dental services, substance abuse treatment services, mental health services, a Resource Mother, etc.
- If you had a very low birthweight baby, you can also receive primary care & dental services, substance abuse treatment services, a Resource Mother, etc.

WHO IS ELIGIBLE?

- Women ages 18-44 who meet monthly family income limits
- If you receive Medicaid and delivered a baby weighing less than 3 lbs, 5 oz, you are eligible for only Resource Mother services.
- If you do not receive Medicaid, you are eligible for family planning services.
- If you do not receive Medicaid or are losing coverage, and delivered a baby weighing less than 3 lbs, 5 oz, you are eligible for IPC services.

PLANNING FOR HEALTHY BABIES (P4HB)



Helping You Grow Your Family On Your Terms.

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)



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

PLANNING FOR HEALTHY BABIES (P4HB)



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PLANNING FOR HEALTHY BABIES (P4HB)

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:



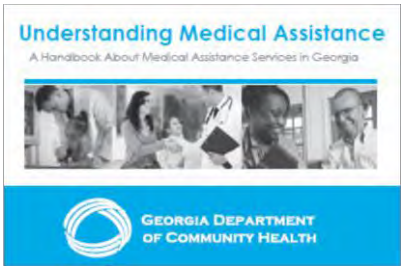
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You may print the booklet from the web at the addresses below:

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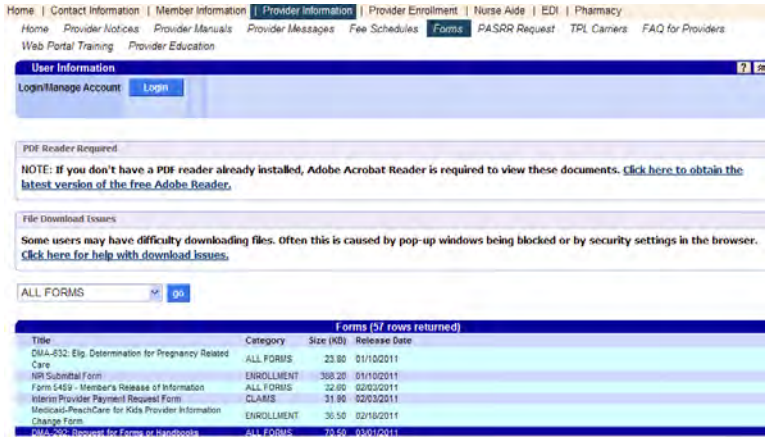
OR

www.dch.ga.gov
Select Medicaid
Select Medicaid Publications from the left column
Under related Files Select “Medical Assistance Plans booklet”



DMA 292 (Request for Forms)

- Download form DMA 292 from the web:



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