

**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: July 1, 2024

**Policy Revisions Record**  
**Part II Policies and Procedures Manual**  
**for Hospital Presumptive Eligibility**  
**Program 2024**

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| 1/1/24   | 502               | Updated citizenship/qualified alien policy regarding lawfully residing pregnant women and children under the age of 19 | M                                  |                                                |
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**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](mailto: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](http://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](mailto: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 2024 Hospital Presumptive Eligibility (HPE) Training Schedule**

Training for 2024 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)**

Currently working on revamping the training and updating for 2024. At this time, live trainings have been postponed at this time. We may be moving to more of a hybrid where part 1 of the new employee training will be recorded and part 2 will be a live portion that will consist of scenarios to test understanding and for participants to ask questions to ensure understanding. Part 3 would be the assessment of which the participant would need to score at least 80% to be qualified to process HPE Applications. Please continue to utilize the existing recorded trainings until further notice.

If you have any questions about training, please contact Teresa Fair at [Teresa.Fair@dch.ga.gov](mailto:Teresa.Fair@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 form 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](mailto: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](mailto: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](mailto: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](mailto: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](mailto: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](mailto: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 Teresa Fair at [Teresa.fair@dch.ga.gov](mailto:Teresa.fair@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](http://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.

**\*Note: Effective 1/1/2024- Lawfully residing pregnant women and children under the age of 19 with a valid immigration status are no longer subjected to the 5-year wait.**

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](mailto: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:
  - o Extract of hospital record on hospital letterhead established at the time of person’s birth
  - o Life, health or other insurance record
  - o An amended US public birth record
  - o Medical clinic, doctor or hospital record indicating a US place of birth
  - o 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, 2023**

| 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            | 63           | 310                                         | 1,670              | 1,870             | 2,573             | N/A      |
| 2            | 86           | 457                                         | 2,266              | 2,538             | 3,492             | 3,748    |
| 3            | 108          | 551                                         | 2,862              | 3,206             | 4,411             | 4,734    |
| 4            | 130          | 653                                         | 3,458              | 3,874             | 5,330             | 5,720    |
| 5            | 153          | 752                                         | 4,055              | 4,543             | 6,250             | 6,707    |
| 6            | 175          | 826                                         | 4,651              | 5,211             | 7,169             | 7,693    |
| 7            | 198          | 903                                         | 5,247              | 5,879             | 8,088             | 8,679    |
| 8            | 220          | 970                                         | 5,844              | 6,547             | 9,007             | 9,666    |
| 9            | 243          | 1,034                                       | 6,440              | 7,215             | 9,926             | 10,652   |
| 10           | 265          | 1,113                                       | 7,036              | 7,883             | 10,845            | 11,638   |
| 11           | 287          | 1,194                                       | 7,632              | 8,551             | 11,764            | 12,625   |
| 12           | 310          | 1,244                                       | 8,229              | 9,219             | 12,683            | 13,611   |

For each additional person over budget group size 12:  
Add \$23 (5% Deduction)  
Add \$50 (Parent/Caretaker with Children under 19)  
Add \$597 (133% FPL)  
Add \$669 (149% FPL)  
Add \$920 (205% FPL)  
Add \$987 (220% FPL)

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.

|                                                      |  |                                     |  |                                |  |
|------------------------------------------------------|--|-------------------------------------|--|--------------------------------|--|
| 2222                                                 |  | 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 Suffix |  | 11 Nonqualified plans               |  | 12a                            |  |
|                                                      |  | 12a                                 |  | 12b                            |  |
|                                                      |  | 12b                                 |  | 12c                            |  |
|                                                      |  | 12c                                 |  | 12d                            |  |
| f Employee's address and ZIP code                    |  | 13                                  |  | 14                             |  |
| 15 State                                             |  | 16 State wages, tips, etc.          |  | 17 State income tax            |  |
| 18                                                   |  | 19 Local wages, tips, etc.          |  | 20 Local income tax            |  |
| 21                                                   |  | 22                                  |  | 23                             |  |
| 24                                                   |  | 25                                  |  | 26                             |  |
| 27                                                   |  | 28                                  |  | 29                             |  |
| 30                                                   |  | 31                                  |  | 32                             |  |
| 33                                                   |  | 34                                  |  | 35                             |  |
| 36                                                   |  | 37                                  |  | 38                             |  |

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:

|                              |     |                                                                                                                             |     |  |  |
|------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------|-----|--|--|
| <b>Adjustments to Income</b> | 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>b</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 =  $\$171.66 \times 4.3333 = \$743.85$   
gross bi-weekly =  $\$171.66 \times 2.1666 = \$371.91$   
gross twice a month =  $\$171.66 \times 2 = \$343.32$

## 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](mailto: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](mailto: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](mailto: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](mailto: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 –  
Hospital Presumptive Eligibility Revised July 1, 2024

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](mailto: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

|                                                                                              | Front | Back |                                                                                                                                        |
|----------------------------------------------------------------------------------------------|-------|------|----------------------------------------------------------------------------------------------------------------------------------------|
| <p>"A-number"</p> <p>Date you became a Permanent Resident (January 1, 1980)</p>              |       |      | <p>This card does not have Port-of-Entry on it.</p>                                                                                    |
| <p>"A-number"</p> <p>Port-of-Entry or office where you were granted adjustment of status</p> |       |      | <p>Date you became a Permanent Resident (April 3, 1980)</p> <p>Port-of-Entry or office where you were granted adjustment of status</p> |
| <p>"A-number"</p>                                                                            |       |      | <p>Date you became a Permanent Resident (July 12, 1991)</p>                                                                            |

**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

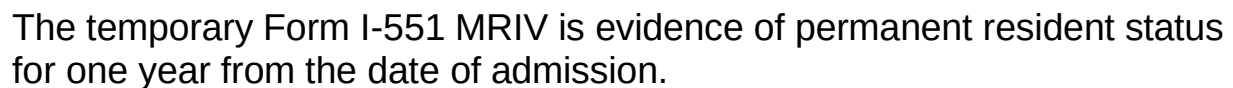


## U.S. Passport Card

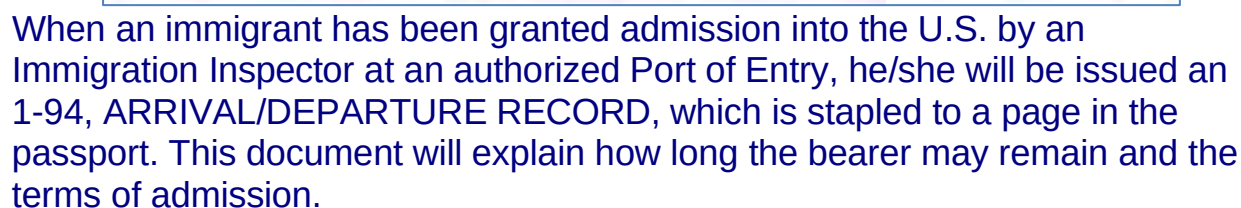
The U.S. Department of State began producing the passport card in July 2008. The passport card is a wallet-size card that can only be used for land and sea travel between the United States and Canada, Mexico, the Caribbean, and Bermuda.



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



Hospital Presumptive Eligibility Revised July 1, 2024



## **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                                    |
| 198 | PATHWAYS (0-50% FPL-CMO)                                            |
| 199 | PATHWAYS (50<100% FPL-CMO)                                          |

## 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 |
|-----|---------------------------------------|

## HOSPITAL 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  |

|  |                         |
|--|-------------------------|
|  | INACTIVE                |
|  | NEW – EFFECTIVE 07/1/23 |

For PE, individuals active in GAMMIS on any of the above aid categories should be referred to DFCS ([www.gateway.ga.gov](http://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](mailto: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](mailto:pecorrections@dch.ga.gov)
- **Women's Health (245)** – Refer to DFCS or you send email to [womenshealth@dhs.ga.gov](mailto: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                                            |
| <u>\$ -259.99</u> | Dental Insurance/Pre-tax deduction ( $60 \times 4.3333 = 259.99$ ) |
| \$ 790.01         | Subtotal net income                                                |
| <u>\$ -136.00</u> | 5% FPL deduction                                                   |
| <b>\$ 654.01</b>  | <b>Total net income</b>                                            |

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 = \$2862

Children Under Age 19 (4) BG of 3 income limit = \$3206

### **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.

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

|                  |                                    |
|------------------|------------------------------------|
| \$2729.97        | Pamela's earned income             |
| <u>\$-108.33</u> | Health Insurance/Pre-tax deduction |
| <b>\$2621.64</b> | <b>Total net income</b>            |

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

Pregnant Women BG of 4 income limit - \$5720

**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

| <b>Form Number</b>    | <b>Page Number</b> | <b>Form Name</b>                                                  | <b>Revision Date</b> |
|-----------------------|--------------------|-------------------------------------------------------------------|----------------------|
| 632H<br>(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)                                       | 09/2023              |
| 634H SP               | F-38               | Notice of Action (Approval) (Spanish)                             | 09/2023              |
| 634H                  | F-39               | Notice of Action (Denial)                                         | 09/2023              |
| 634H SP               | F-40               | Notice of Action (Denial) (Spanish)                               | 09/2023              |
| 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                              | 09/2023              |
| n/a                   | F-59               | Quick Guide on PE Medical Assistance (Spanish)                    | 09/2023              |
| n/a                   | F-61               | PE Manual Updates                                                 | 09/2023              |
| n/a                   | F-62               | SSI Pregnant Women Update                                         | 09/2023              |
| 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](mailto: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.<br>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:                                      | <p>Enter the type of income:<br/> <b>C</b> = Commissions<br/> <b>W</b> = Earned income (wages or salaries)<br/> <b>OU</b> = Other unearned income<br/> <b>P</b> = Pensions<br/> <b>SE</b> = Self-employment<br/> Enter the amount of the income.</p> <p>Enter the frequency of the income:<br/> <b>A</b> = Annually<br/> <b>B</b> = Biweekly<br/> <b>W</b> = Weekly<br/> <b>SM</b> = Semi-monthly<br/> <b>M</b> = Monthly<br/> Convert all income to a monthly amount.</p> |
| 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.<br><b>Note:</b> 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.

**Note:** Effective 1/1/2023 Individuals under the age of 26, who turned 18 on or after 1/1/23 and were enrolled in Medicaid in **ANY** state while in foster care and were in foster care under the responsibility of **ANY** state upon attaining age 18 and are not receiving another Medicaid class of assistance (COA) will be eligible for Former Foster Care COA.

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

HOSPITAL PRESUMPTIVE ELIGIBILITY MEDICAL ASSISTANCE

MEDICAL ASSISTANCE IDENTIFICATION NUMBER

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 <input type="radio"/> YES <input type="radio"/> NO<br>NON-TAX FILER HOUSEHOLD <input type="radio"/> YES <input type="radio"/> NO |    |           |        | DATE<br>OF<br>BIRTH<br>MM/DD/YYYY | *<br>RACE | GENDER | RELATION<br>TO<br>APPLICANT | US CITIZEN, US<br>NATIONAL OR<br>LAWFULLY PRESENT<br>IMMIGRANT?<br>Y/N | MONTHLY GROSS INCOME |        |      |                   | MONTHLY DEDUCTIONS |      | MONTHLY<br>NET<br>INCOME |
|    | FIRST NAME                                                                                                                                           | MI | LAST NAME | SUFFIX |                                   |           |        |                             |                                                                        | TYPE                 | AMOUNT | FREQ | MONTHLY<br>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 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](http://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](mailto: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



**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](mailto:pecorrections@dch.ga.gov). These documents are available in English and Spanish.



## Application for Health Coverage & Help Paying Costs

### THINGS TO



#### Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from **Medical Assistance**.  
You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).



#### Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit [HealthCare.gov](https://www.healthcare.ga.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](https://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](https://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](https://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](https://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<br>( ) —                                                                                                    |           | 15. Other phone number<br>( ) — |                              |
| 16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No |           |                                 |                              |
| Email address: _____                                                                                                         |           |                                 |                              |
| 17. What is your preferred spoken or written language (if not English)?<br>_____                                             |           |                                 |                              |

## STEP 2 Tell us about your family.

### Who do you need to include on this application?

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

#### DO Include:

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

#### You DON'T have to include:

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

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

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



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

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## STEP 2: PERSON 1 (Start with yourself)

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

|                                                       |                                                                      |                                        |
|-------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------|
| 1. First name, Middle name, Last name, & Suffix _____ |                                                                      | 2. Relationship to you?<br><b>SELF</b> |
| 3. Date of birth (mm/dd/yyyy) _____                   | 4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |                                        |

5. Social Security number (SSN) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

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

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

☐ **YES. If yes**, please answer questions a–c.

☐ **NO. If no**, skip to question c.

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

If yes, name of spouse: \_\_\_\_\_

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

If yes, list name(s) of dependents: \_\_\_\_\_

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

If yes, please list the name of the tax filer: \_\_\_\_\_

How are you related to the tax filer? \_\_\_\_\_

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

### 8. Do you need health coverage?

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

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no**, SKIP to the income questions on page 3.  
Leave the rest of this page blank.

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

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

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

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

a. Immigration document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

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

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

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

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

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

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

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other \_\_\_\_\_

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

☐ White

☐ American Indian or Alaska

☐ Filipino

☐ Vietnamese

☐ Guamanian or Chamorro

☐ Black or African American

☐ Native

☐ Japanese

☐ Other Asian

☐ Samoan

☐ Asian Indian

☐ Korean

☐ Native Hawaiian

☐ Other Pacific Islander

☐ Chinese

☐ Other \_\_\_\_\_



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

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## STEP 2: PERSON 2

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

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

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

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

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## STEP 2: PERSON 2

### 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<br>( ) - |
| 22. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly<br>\$ |                                    |
| 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<br>( ) - |
| 26. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly<br>\$ |                                    |
| 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).

- |                                              |    |            |                                              |    |            |
|----------------------------------------------|----|------------|----------------------------------------------|----|------------|
| <input type="checkbox"/> None                |    |            |                                              |    |            |
| <input type="checkbox"/> Unemployment        | \$ | How often? | <input type="checkbox"/> Net farming/fishing | \$ | How often? |
| <input type="checkbox"/> Pensions            | \$ | How often? | <input type="checkbox"/> Net rental/royalty  | \$ | How often? |
| <input type="checkbox"/> Social Security     | \$ | How often? | <input type="checkbox"/> Other income        | \$ | How often? |
| <input type="checkbox"/> Retirement accounts | \$ | How often? | Type: _____                                  |    |            |
| <input type="checkbox"/> Alimony received    | \$ | How often? |                                              |    |            |

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

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

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

- |                                                |    |            |                                           |    |            |
|------------------------------------------------|----|------------|-------------------------------------------|----|------------|
| <input type="checkbox"/> Alimony paid          | \$ | How often? | <input type="checkbox"/> Other deductions | \$ | How often? |
| <input type="checkbox"/> Student loan interest | \$ | How often? | Type: _____                               |    |            |

#### 32. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

|                                                |                                                                                    |
|------------------------------------------------|------------------------------------------------------------------------------------|
| PERSON 2's total income <b>this year</b><br>\$ | PERSON 2's total income <b>next year</b> (if you think it will be different)<br>\$ |
|------------------------------------------------|------------------------------------------------------------------------------------|

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

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## STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

### 1. Are you or is anyone in your family American Indian or Alaska Native?

- ☐ If No, skip to Step 4.  
☐ Yes. If yes, go to Attachment B.

## STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

### 1. Is anyone enrolled in health coverage now from the following?

- ☐ YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

- ☐ Medical Assistance \_\_\_\_\_  
☐ Medicare \_\_\_\_\_  
☐ TRICARE (Don't check if you have direct care or Line of Duty)  
☐ VA Health Care Programs \_\_\_\_\_  
☐ Peace Corps \_\_\_\_\_

- ☐ Employer insurance \_\_\_\_\_  
☐ Name of health insurance: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
Is this COBRA coverage? ☐ Yes ☐ No  
Is this a retiree health plan? ☐ Yes ☐ No  
☐ Other  
Name of health insurance: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
Is this a limited-benefit plan (like a school accident policy)?  
☐ Yes ☐ No

### 2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

- ☐ YES. If yes, you'll need to complete and include Attachment A.  
☐ NO. If no, continue to Step 5.

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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## STEP 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](https://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](https://gateway.ga.gov) or call us at 1-877-423-4746. Para obtener una copia de este formulario en Español, llame 1-877-423-4746. If you need help in a language other than English, call 1-877-423-4746 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-255-0135.

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## **STEP 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](http://www.SOS.ga.gov).

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

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# 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<br>____ - ____ - ____ |
|----------------------------------------|----------------------------------------------------------|

### EMPLOYER Information

|                                                                    |                                                        |             |
|--------------------------------------------------------------------|--------------------------------------------------------|-------------|
| 3. Employer name                                                   | 4. Employer Identification Number (EIN)<br>____ - ____ |             |
| 5. Employer address                                                | 6. Employer phone number<br>( ) - ____                 |             |
| 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)<br>( ) - ____           | 12. Email address                                      |             |

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

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? \_\_\_\_\_

List the names of anyone else who is eligible for coverage from this job. (mm/dd/yyyy)

Name: \_\_\_\_\_ Name: \_\_\_\_\_ Name: \_\_\_\_\_

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

Tell us about the health plan offered by this employer.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 15. For the lowest-cost plan that meets the minimum value standard* offered <b>only to the employee</b> (don't include family plans):<br>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.<br>a. How much would the employee have to pay in premiums for this plan? \$ _____<br>b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly                                                                                         |
| 16. What change will the employer make for the new plan year (if known)?<br><input type="checkbox"/> Employer won't offer health coverage<br><input type="checkbox"/> 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.)<br>a. How much will the employee have to pay in premiums for that plan? \$ _____<br>b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly<br>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)(i) of the Internal Revenue Code of 1986).

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

Form 94a Appendix A (9/17)



# EMPLOYER COVERAGE TOOL



GEORGIA DEPARTMENT OF HUMAN RESOURCES  
DIVISION OF PUBLIC AND COMMUNITY HEALTH



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<br>____ - ____ - ____ |
|----------------------------------------|-------------------------------------------------|



## EMPLOYER Information

Ask the employer for this information.

|                                                                    |                                                        |             |
|--------------------------------------------------------------------|--------------------------------------------------------|-------------|
| 3. Employer name                                                   | 4. Employer Identification Number (EIN)<br>____ - ____ |             |
| 5. Employer address                                                | 6. Employer phone number<br>( ) - ____ - ____          |             |
| 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)<br>( ) - ____ - ____    | 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](http://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<br>(First name, Middle name, Last name)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <div>First Middle</div> <div>Last</div>                                                                                                                                                                                                                                                                                     | <div>First Middle</div> <div>Last</div>                                                                                                                                                                                                                                                                                     |
| 2. Member of a federally recognized tribe?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Yes<br><b>If yes, tribe name</b><br><div></div> <input type="checkbox"/> No                                                                                                                                                                                                                        | <input type="checkbox"/> Yes<br><b>If yes, tribe name</b><br><div></div> <input type="checkbox"/> 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?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><b>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?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><b>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?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> 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:<br><ul style="list-style-type: none"> <li>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties</li> <li>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)</li> <li>Money from selling things that have cultural significance</li> </ul> | <div>\$ _____</div> <div>How often? _____</div>                                                                                                                                                                                                                                                                             | <div>\$ _____</div> <div>How often? _____</div>                                                                                                                                                                                                                                                                             |



**NEED HELP WITH YOUR APPLICATION?** Visit [gateway.ga.gov](http://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<br>( ) —                                                                                                                                             |          |                              |
| 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](https://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)



## Solicitud para Cobertura de Salud y Ayuda Pagando el Costo

### 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.ga.gov](https://www.healthcare.ga.gov).
- Las familias que tienen inmigrantes pueden solicitar. Usted puede solicitar para su hijo(a) aunque usted no sea elegible para cobertura. Solicitar no afectará su estado migratorio o su oportunidad de convertirse en residente permanente o ciudadano(a).
- Si alguien le está ayudando a llenar esta solicitud, usted podría necesitar completar el Anejo C.



#### Solicite más rápido en línea

Solicite más rápido en línea [gateway.ga.gov](https://gateway.ga.gov).



#### Qué necesita para solicitar

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



#### ¿Por qué pedimos esta

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



#### ¿Qué pasa después?

Envíe su solicitud completa y firmada a la dirección que aparece en la página 8. **Si no tiene toda la información que pedimos, firméla y preséntela de todas maneras.** Nosotros haremos un seguimiento con usted dentro de 1 a 2 semanas. Usted recibirá instrucciones sobre los siguientes pasos necesarios para completar su cobertura de salud. Si no recibe ninguna noticia de nosotros, visite [gateway.ga.gov](https://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](https://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](https://gateway.ga.gov) o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea Inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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

## Paso 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<br>( ) —                                                                                                      |            | 15. Otro número de teléfono<br>( ) — |                                   |
| 16. ¿Quiere recibir información por correo electrónico sobre esta solicitud? <input type="checkbox"/> Sí <input type="checkbox"/> 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 necesiten 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.



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

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

Página 1 de 8

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

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------|--------------------------------------------------------------|-----------------------------------|-------------------------------------|------------------------------------------------|--------------------------------------|----------------------------------|----------------------------------------|--|--------------------------------|----------------------------------|--------------------------------------------|
| 1. Primer nombre, segundo nombre, Apellido, Sufijo _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                              | 2. Parentesco con usted<br><b>USTED MISMO</b> |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 3. Fecha de nacimiento (MM/DD/AAAA): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. Sexo <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 5. Número de Seguro Social (SSN) _____<br><b>Necesitamos esto si quiere cobertura de salud y tiene un Número de Seguro Social.</b> 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 <a href="https://www.socialsecurity.gov">socialsecurity.gov</a> . Los usuarios de TTY deben llamar al 1-800-255-0135.                                                                                                                                                                                                                                                                                                                                                                           |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 6. ¿Planea presentar una declaración de impuesto federal el PRÓXIMO AÑO?<br>(Aunque no presente una declaración de impuestos, usted puede solicitar para seguro de salud.)<br><input type="checkbox"/> <b>SI. Si sí</b> , por favor, conteste las preguntas a-c. <input type="checkbox"/> <b>NO. Si no</b> , salte a la pregunta c.<br>a. ¿Va a declarar conjunto con su cónyuge? <input type="checkbox"/> Sí <input type="checkbox"/> No<br><b>Si sí</b> , nombre del cónyuge: _____<br>b. ¿Va a reclamar algún dependiente en su declaración de impuestos? <input type="checkbox"/> Sí <input type="checkbox"/> No<br><b>Si sí</b> , haga una lista del (los) dependiente(s): _____<br>c. ¿Será usted reclamado(a) como un(a) dependiente en la declaración de impuestos de otra persona? <input type="checkbox"/> Sí <input type="checkbox"/> No<br><b>Si sí</b> , por favor mencione el nombre del declarante de impuestos: _____<br>¿Cuál es su parentesco con el declarante de impuestos? _____ |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 7. ¿Está embarazada? <input type="checkbox"/> Sí <input type="checkbox"/> No Si sí, ¿cuál es la fecha esperada de alumbramiento / / ; y cuántos bebés está esperando? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 8. ¿Necesita cobertura de salud?<br>(Aunque tenga seguro, puede haber un programa con mejor cobertura o un costo más bajo.)<br><input type="checkbox"/> <b>SI. Si sí</b> , conteste todas las preguntas abajo. <input type="checkbox"/> <b>NO. Si no</b> , 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? <input type="checkbox"/> Sí <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 10. ¿Es usted un(a) ciudadano(a) de los Estados Unidos o nacional de los Estados Unidos? <input type="checkbox"/> Sí <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 11. Si usted no es ciudadano(a) o nacional de los Estados Unidos, ¿es un inmigrante calificado?<br><input type="checkbox"/> Sí. Llene la información de su tipo de documento y número de ID abajo.<br>a. Tipo de documento de inmigración _____ b. Número de ID de documento _____<br>c. ¿Ha vivido usted en los Estados Unidos desde el 1996? <input type="checkbox"/> Sí <input type="checkbox"/> No d. ¿Es usted o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? <input type="checkbox"/> Sí <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 12. ¿Usted quiere ayuda para pagar facturas médicas de los últimos tres meses? <input type="checkbox"/> Sí <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 13. ¿Vive usted con al menos un menor de 19 años y usted es el cuidador(a) principal de este menor? <input type="checkbox"/> Sí <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 14. ¿Es usted un estudiante a tiempo completo? <input type="checkbox"/> Sí <input type="checkbox"/> No 15. ¿Estuvo usted en cuidado tutelar a la edad de 18 años o mayor? <input type="checkbox"/> Sí <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 16. Si es hispano/latino (OPCIONAL—marque todas las que aplican.)<br><input type="checkbox"/> Mexicano <input type="checkbox"/> Mexicanoamericano <input type="checkbox"/> Chicano <input type="checkbox"/> Puertorriqueño <input type="checkbox"/> Cubano <input type="checkbox"/> Otro _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                              |                                               |                                            |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| 17. Raza (OPCIONAL—marque todas las que aplican.)<br><table style="width: 100%; border: none;"><tr><td><input type="checkbox"/> Blanco</td><td><input type="checkbox"/> Indígena estadounidense o de Alaska</td><td><input type="checkbox"/> Filipino</td><td><input type="checkbox"/> Vietnamita</td></tr><tr><td><input type="checkbox"/> Negro o afroamericano</td><td><input type="checkbox"/> De la India</td><td><input type="checkbox"/> Japonés</td><td><input type="checkbox"/> Otro asiático</td></tr><tr><td></td><td><input type="checkbox"/> Chino</td><td><input type="checkbox"/> Coreano</td><td><input type="checkbox"/> Indígena de Hawái</td></tr></table>                                                                                                                                                                                                                                                                                                                         |                                                                              |                                               | <input type="checkbox"/> Blanco            | <input type="checkbox"/> Indígena estadounidense o de Alaska | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamita | <input type="checkbox"/> Negro o afroamericano | <input type="checkbox"/> De la India | <input type="checkbox"/> Japonés | <input type="checkbox"/> Otro asiático |  | <input type="checkbox"/> Chino | <input type="checkbox"/> Coreano | <input type="checkbox"/> Indígena de Hawái |
| <input type="checkbox"/> Blanco                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Indígena estadounidense o de Alaska                 | <input type="checkbox"/> Filipino             | <input type="checkbox"/> Vietnamita        |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
| <input type="checkbox"/> Negro o afroamericano                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> De la India                                         | <input type="checkbox"/> Japonés              | <input type="checkbox"/> Otro asiático     |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Chino                                               | <input type="checkbox"/> Coreano              | <input type="checkbox"/> Indígena de Hawái |                                                              |                                   |                                     |                                                |                                      |                                  |                                        |  |                                |                                  |                                            |

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

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

### Trabajo actual e Información de ingresos

☐ **Empleado**

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

☐ **No empleado**

Salte a la pregunta 28.

☐ **Trabajo por cuenta propia**

Salte a la pregunta 27.

#### TRABAJO ACTUAL 1:

18. Nombre y dirección del empleador

19. N° de teléfono del empleador

( ) -

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

\$

21. Promedio de horas trabajadas cada SEMANA

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

22. Nombre y dirección del empleador

23. N° de teléfono del empleador

( ) -

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

\$

25. Promedio de horas trabajadas cada SEMANA

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

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

a. tipo de trabajo

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

\$

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

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

☐ Ninguno

☐ desempleo

\$

¿Con qué

☐ Cantidad neta de pesca u cultivos

\$

¿Frecuencia?

☐ Pensiones

\$

¿Con qué

☐ Rental/regalías netas

\$

¿Frecuencia

☐ Seguro Social

\$

¿Con qué

Otros ingresos

\$

¿Frecuencia

☐ Cuentas de retiro

\$

¿Con qué

Tipo

☐ Pensión alimenticia

\$

¿Con qué

#### 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.na.gov](http://gateway.na.gov) o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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30. **INGRESO ANUAL:** Complete sólo si sus ingresos cambian cada mes. Si no espera cambios en sus ingresos mensuales, salte a la próxima persona.

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

**GRACIAS! Es todo lo que necesitamos saber de usted.**

## PASO 2: PERSONA 2

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

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

|                                      |                                                                              |
|--------------------------------------|------------------------------------------------------------------------------|
| 3. Fecha de nacimiento (MM/DD/AAAA): | 4. Sexo <input type="checkbox"/> Masculino <input type="checkbox"/> 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

**Si no, 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 redamar 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. Si sí, ¿cuál es la fecha esperada de alumbramiento (\_\_\_/\_\_\_/\_\_\_) y cuántos bebés está esperando? \_\_\_\_\_

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

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

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

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

12. **Si la PERSONA # 2 no es ciudadano(a) o nacional de los Estados Unidos, ¿es un inmigrante calificado?**

☐ **Sí.** Uene la información de su tipo de documento y número de ID abajo.

a. Tipo de documento de inmigración \_\_\_\_\_ b. Número de ID de documento \_\_\_\_\_

c. ¿Ha vivido la PERSONA # 2 en los Estados Unidos desde el 1996? ☐ Sí ☐ No d. ¿Es la PERSONA # 2 o su cónyuge o padre (madre) un veterano o un miembro activo del ejército de los Estados Unidos? ☐ Sí ☐ No

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

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|                                                                                                                                                    |                                                                                                                                                                               |                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| 13. ¿La PERSONA # 2 quiere ayuda para pagar facturas médicas de los últimos tres meses?<br><input type="checkbox"/> Sí <input type="checkbox"/> 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?<br><input type="checkbox"/> Sí <input type="checkbox"/> No | 15. ¿Estuvo la PERSONA # 2 en cuidado tutelar a la edad de 18 o mayor?<br><input type="checkbox"/> Sí <input type="checkbox"/> 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.)

|                                                |                                                              |                                            |                                        |
|------------------------------------------------|--------------------------------------------------------------|--------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Blanco                | <input type="checkbox"/> Indígena estadounidense o de Alaska | <input type="checkbox"/> Filipino          | <input type="checkbox"/> Vietnamita    |
| <input type="checkbox"/> Negro o afroamericano | <input type="checkbox"/> De la India                         | <input type="checkbox"/> Japonés           | <input type="checkbox"/> Otro asiático |
| <input type="checkbox"/> Chino                 | <input type="checkbox"/> Coreano                             | <input type="checkbox"/> Indígena de Hawái |                                        |

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



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

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## PASO 2: PERSONA 2

### Trabajo actual e Información de ingresos

☐ **Empleado**

Si está empleado actualmente, díganos sobre sus ingresos. 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<br>( ) - |
| 22. Sueldos/propinas (antes de impuestos) <input type="checkbox"/> por hora <input type="checkbox"/> semanal <input type="checkbox"/> cada dos semanas <input type="checkbox"/> quincenal <input type="checkbox"/> mensual <input type="checkbox"/> anual<br>\$ |                                           |
| 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<br>( ) - |
| 26. Sueldos/propinas (antes de impuestos) <input type="checkbox"/> por hora <input type="checkbox"/> semanal <input type="checkbox"/> cada dos semanas <input type="checkbox"/> quincenal <input type="checkbox"/> mensual <input type="checkbox"/> anual<br>\$ |                                           |
| 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.

|                                              |                                                            |    |              |
|----------------------------------------------|------------------------------------------------------------|----|--------------|
| <input type="checkbox"/> Ninguno             | <input type="checkbox"/> Cantidad neta de pesca u cultivos | \$ | ¿Frecuencia? |
| <input type="checkbox"/> desempleo           | <input type="checkbox"/> Rental/regalis netas              | \$ | ¿Frecuencia  |
| <input type="checkbox"/> Pensiones           | Otros ingresos                                             | \$ | ¿Frecuencia  |
| <input type="checkbox"/> Seguro Social       | Tipo                                                       |    |              |
| <input type="checkbox"/> Cuentas de retiro   |                                                            |    |              |
| <input type="checkbox"/> Pensión alimenticia |                                                            |    |              |

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

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

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

|                                                              |    |               |                   |    |               |
|--------------------------------------------------------------|----|---------------|-------------------|----|---------------|
| <input type="checkbox"/> pensión alimenticia                 | \$ | ¿Cada cuánto? | Otras deducciones | \$ | ¿Cada cuánto? |
| <input type="checkbox"/> 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 <b>este año</b> para la PERSONA # 2<br>\$ | El total de ingresos el <b>próximo año</b> para la PERSONA # 2 (si piensa que será diferente)<br>\$ |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|

**¡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](https://gateway.ga.gov) o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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## PASO 3

### Familiares de indios americanos o nativos de Alaska (AI/AN, por sus siglas en 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](http://gateway.ga.gov) o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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## PASO 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](http://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.
- Confirmando 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 verificar 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 representante 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](http://gateway.ga.gov) o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en español, llame al 1-877-423-4746. Si necesita ayuda en algún idioma que no sea inglés, llame al 1-877-423-4746 y dígame al representante de atención al cliente el idioma que necesita. Le buscaremos ayuda sin costo alguno. Los usuarios de TTY deben llamar al 1-800-255-0135.

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

Página 8 de 8

## **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](http://www.sos.ga.gov).



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

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

Página 10 de 8



## 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<br>____ - ____ - ____ |
|--------------------------------------------------------------|---------------------------------------------------------------------|

### Información sobre el EMPLEADOR

|                                                                                                   |                                                                |                  |
|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------|
| 3. Nombre del empleador                                                                           | 4. Número de Identificación del Empleador (EIN)<br>____ - ____ |                  |
| 5. Dirección del empleador                                                                        | 6. Número de teléfono del empleador<br>( ) - ____              |                  |
| 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)<br>( ) - ____                                     | 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*? <input type="checkbox"/> Sí <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 15. Para el plan de salud más barato que satisfaga el estándar del valor mínimo* ofrecido <b>sólo al empleado</b> (no incluya planes familiares):<br>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.<br>a. ¿Cuánto, en primas, tendría que pagar el empleado por este plan? \$ _____<br>b. ¿Con qué frecuencia? <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces al mes <input type="checkbox"/> Mensual <input type="checkbox"/> Trimestral <input type="checkbox"/> Anual                                                                                           |
| 16. ¿Qué cambio hará el empleador para el nuevo año del plan (si se sabe)?<br><input type="checkbox"/> El empleador no ofrecerá cobertura de salud<br><input type="checkbox"/> 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.)<br>a. ¿Cuánto, en primas, tendrá que pagar el empleado por ese plan? \$ _____<br>b. ¿Con qué frecuencia? <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces al mes <input type="checkbox"/> Mensual <input type="checkbox"/> Trimestral <input type="checkbox"/> Anual<br>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](http://gateway.ga.gov) o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame al **1-877-423-4746**. Si necesita ayuda en otro idioma que no sea el inglés, llame al **1-877-423-4746** y dígame al representante del servicio al cliente qué idioma necesita. Nosotros le conseguiremos ayuda gratis. Los usuarios de TTY deben llamar al **1-800-255-0135**.

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

# HERRAMIENTA DE COBERTURA DEL



GOVERNMENT OF GEORGIA  
DEPARTMENT OF COMMUNITY HEALTH  
BUREAU OF HEALTH SERVICES



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

Form Approved  
OMB No. 0938-1191

## EMPLEADOR

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

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



### Información sobre el EMPLEADO

El empleado tiene que llenar esta sección.

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



### Información sobre el EMPLEADOR

Pídale al empleador esta información.

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

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

☐ Sí (Continúe)

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

☐ No (PARE y devuelva este formulario al empleado)

Cuéntenos sobre el plan de salud ofrecido por este empleador.

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

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

☐ No

(Vaya a la pregunta 14)

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

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

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

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

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

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

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

☐ El empleador no ofrecerá cobertura de salud

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

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

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

Fecha del cambio (mm/dd/aaaa): \_\_\_\_

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

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



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



## 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<br>(Nombre de pila, Nombre del medio, Apellido)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <div>Nombre de pila      Nombre del medio</div> <div>Apellido</div>                                                                                                                                                                                                                                                                                                  | <div>Nombre de pila      Nombre del medio</div> <div>Apellido</div>                                                                                                                                                                                                                                                                                                  |
| 2. ¿Miembro de una tribu reconocida por el gobierno federal?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Sí<br><b>Si la respuesta es sí, nombre de la tribu</b> _____<br><input type="checkbox"/> No                                                                                                                                                                                                                                                 | <input type="checkbox"/> Sí<br><b>Si la respuesta es sí, nombre de la tribu</b> _____<br><input type="checkbox"/> 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?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Sí<br><input type="checkbox"/> No<br><b>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?</b><br><div>Sí      No</div> | <input type="checkbox"/> Sí<br><input type="checkbox"/> No<br><b>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?</b><br><div>Sí      No</div> |
| 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: <ul style="list-style-type: none"> <li>• Pagos per cápita de una tribu que vienen de recursos naturales, uso de derechos, arrendamientos, o regalías</li> <li>• 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)</li> <li>• Dinero de la venta de cosas que tienen un significado cultural</li> </ul> | <div>\$ _____</div> <div>¿Con qué frecuencia? _____</div>                                                                                                                                                                                                                                                                                                            | <div>\$ _____</div> <div>¿Con qué frecuencia? _____</div>                                                                                                                                                                                                                                                                                                            |

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

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

## ANEXO C



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



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

Form Approved  
OMB No. 0938-1191

### Ayuda para completar esta solicitud

#### Usted puede escoger a un representante autorizado.

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

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

|                                                                                                                                                                                                |           |                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------------------------------|
| 1. Nombre del representante autorizado (Nombre de pila, Nombre del medio, Apellido)                                                                                                            |           |                                    |
| 2. Dirección                                                                                                                                                                                   |           | 3. Departamento o número de suite  |
| 4. Ciudad                                                                                                                                                                                      | 5. Estado | 6. Código postal                   |
| 7. Número de teléfono<br>( ) -                                                                                                                                                                 |           |                                    |
| 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](http://gateway.ga.gov) o llámenos al 1-877-423-4746. Para obtener una copia de este formulario en Español, llame al 1-877-423-4746. Si necesita ayuda en otro idioma que no sea el inglés, llame al 1-877-423-4746 y dígame al representante del servicio al cliente qué idioma necesita. Nosotros le conseguiremos ayuda gratis. Los usuarios de TTY deben llamar al 1-800-255-0135.

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

## NOTICE OF ACTION Form DMA 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](mailto: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](mailto: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.



## 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 9/14/23)



Brian P. Kemp, Gobernador

Russel Carlson, Comisionada

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | [www.dch.georgia.gov](http://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 \_\_\_\_\_

Título \_\_\_\_\_

Número de Teléfono \_\_\_\_\_

Número de Identificación del  
Hospital Calificado \_\_\_\_\_

634H Aprobación SP (Revisado el 9/14/23)

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

Equal Opportunity Employer



## NOTICE OF ACTION

### Presumptive Eligibility Medical Assistance

Name

Address

City

State GA Zip Code

Date



#### 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](http://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 9/14/23)



Brian P. Kemp, Gobernador

Russel Carlson, Comisionada

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | [www.dch.georgia.gov](http://www.dch.georgia.gov)

**AVISO DE ACCIÓN**  
**Presuntive 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 motivo de la negación es:

Elige un artículo

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](http://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

Título

Número de Telefono

Número de Identificación del  
Hospital Calificado

634H Negación SP (Revisado el 9/14/23)

# **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 or federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

*Right to an Electronic Copy of Electronic Medical Records.* If your 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 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, 29<sup>th</sup> Floor  
Atlanta, GA 30303-3142  
[HIPAADHS@dhs.ga.gov](mailto: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 RECOPIAMOS:**

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, 29<sup>th</sup> Floor  
Atlanta, GA 30303-3142  
[HIPAADHS@dhs.ga.gov](mailto: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 SSN: 123-45-6789  
Address PHONE NO: Day time phone number

TYPE OF CASE: ☒ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION  
 (Check all that apply) ☐ HIPV 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 step-parent have any private, group or government health insurance that pays any of the cost of your medical care?

☒ YES ☐ NO

Is policyholder an Absent Parent?

☐ YES ☒ NO

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

(City)

Columbus  
(State)

GA  
(Zip)

33392

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 Coverages (circle those which apply)

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

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

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

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

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

EFFECTIVE DATE OF MEDICAID ELIGIBILITY 01/01/xx

Case Worker Name: Qualified Provider Worker Phone No: Direct Phone County \_\_\_\_\_

DHGA-285-REV. (01/00)

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) ☐ HIPPA 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 431.115-119). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

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

☐ YES ☐ NO

Does your spouse, parent or stepparent have any private, group or government health insurance that pays any of the cost of your medical care?

☐ YES ☐ NO

Is policyholder an Absent Parent?

☐ YES ☐ NO

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

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

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

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

(Insurance Company Name)

(Telephone Number)

(Address)

(City)

(State)

(Zip)

(Policyholder Name)

(Policyholder SSN)

(Policy Number)

(Policyholder DOB)

(Policy Effective Date)

(Policy Termination Date)

(Employer Name)

(Telephone Number)

(Employer Address)

(City)

(State)

(Zip)

Types of Coverage (circle those which apply)

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

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

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

Signed \_\_\_\_\_

Date \_\_\_\_\_

Member or Authorized Person

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.



## 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](http://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](http://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 9/14/23



## 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 retroactiva 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](http://gateway.ga.gov).

Poco después de ser elegible para recibir Asistencia Médica completa, se inscribirá en una de 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](http://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 9/14/23

## **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](mailto: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.





## **Supplemental Security Income (SSI) Pregnant Women Update**

Email to DCH: [pecorrections@dch.ga.gov](mailto: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**

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 9/14/23

# 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 Run 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 Run 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:

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

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

Sign in to the Georgia Medicaid

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

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

**Sign in to Georgia Medicaid** [Help](#)

Username:

Password:

**Sign In**

Georgia Medicaid  
Forgot your password?

**User Name** (points to Username field)

**Password** (points to Password field)

**Get Password** (points to Forgot your password? link)

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**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

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

**Georgia Medicaid Home** [Sign Out](#)

Public Health Welcome to Georgia Medicaid

**Applications**

| Application                                         | Description                                                                                       |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <a href="#">MEUPS Account Management Web Portal</a> | Manages contact information, password, and authorizations for applications. Web Portal Production |

**Messages**

There are no new messages.

**To Access the Web Go Here** (points to MEUPS Account Management Web Portal link)

**To Change Your Password and Personal Information Go Here. It Takes You Here.** (points to MEUPS Account Management Web Portal link)

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**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

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

**Account Home** [Close Application](#)

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

Good Morning Public Health

Please select a button above to view or edit your account.

Password Last Modified: 10/26/2010 11:24:37 AM  
Your password will expire in 11 days

**Passwords Expire in 60 Days. This Screen Tells You the Days Remaining.** (points to password expiration notice)

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## Going to the Web:

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

[ Refresh session ] You have approximately 19 minutes until your session will expire. Tuesday, December 14, 2010

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Home Publication Search Site Map Site Settings Language Selection

(click to hide) Alert Message posted 12/9/2010

**Trading Partner PIN Activation**

All Trading Partners (those who submit EDI batch files to Georgia Medicaid) will be receiving a Trading Partner Personal Identification Number (PIN) letter.

If you are a trading partner and you have not received your letter by Sunday, October 24, 2010, then you should contact EDI Services at (770) 325-9590 or toll-free at (877) 261-8785.

Those trading partners who have their PIN letter should [click here to register at our Trading Partner PIN Activation page.](#)

**Attention Payees Receiving ERAs.**

**Important:** Provider's enrolled for Electronic Remittance Advices (ERA's) must activate their Payee Provider Web Portal PIN's that they received in the mail.

ERA's are generated using the PAYEE Provider ID; therefore, if you wish to delegate these 835 ERA's so that your clearinghouse/software vendor/billing

(click to hide) Alert Message posted 10/28/2010

**Switch User or Switch Trading Partner panel**

To begin acting as a particular provider or trading partner, use the Switch Provider or Switch Trading Partner panel below.  
Once a selection has been made and confirmed, additional menu items will be displayed based on the roles delegated to you.

**User Information - Agent PHALLEN** ?

**Switch Provider** ?

National Provider ID  Address   
Medicaid Provider ID  City   
Name  Zip

**If you have more than one choice choose your office.**

(2 rows returned)

| National Provider ID | Medicaid Provider ID | Provider Type        | Name | Address | City | State | Zip | + 4 |
|----------------------|----------------------|----------------------|------|---------|------|-------|-----|-----|
|                      |                      | Public Health Agency |      |         |      |       |     |     |
|                      |                      | Public Health Agency |      |         |      |       |     |     |

Select row above to switch to the desired provider.

## Messages:

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

Welcome Public Health ?

[ Refresh session ] You have approximately 19 minutes until your session will expire. Tuesday, December 14, 2010

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy

Account | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization

Home Messages Switch Eligibility Request Eligibility

**User Information - Provider 000457729N** ?

**Messages** Top ?

| Category       | Subject                                            | Sent Date  | Effective Date | End Date   | Remove                   |
|----------------|----------------------------------------------------|------------|----------------|------------|--------------------------|
| PROVIDER ALERT | Suspended Claim Attachments                        | 12/01/2010 | 12/01/2010     | 12/31/2010 | <input type="checkbox"/> |
| PROVIDER ALERT | EOB / Adjustment Reason / Remark Codes Crosswalk   | 12/01/2010 | 12/01/2010     | 12/20/2010 | <input type="checkbox"/> |
| PROVIDER ALERT | 5010 Workshops                                     | 11/22/2010 | 11/15/2010     | 12/20/2010 | <input type="checkbox"/> |
| NOTIFICATION   | Electronic Claims Require Identifying Service Loca | 11/15/2010 | 11/12/2010     | 12/15/2010 | <input type="checkbox"/> |

Select All Save Deselect All

## Screening on the web portal:

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

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy  
Account | Providers | Training | Claims | **Eligibility** | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

Home **Eligibility Request**

(click to hide) Alert Message posted 2  
This site is for testing purposes only!  
This site is for testing purposes only. Any information entered is for testing purposes only.

Newborn Activations  
Hospital Activations  
Pregnant Women Activations  
Women's Health Activations

**User Information - Provider 000155933X**

**Note:** If a member is enrolled in a managed care plan on the date of admission, the plan is responsible for the entire stay as long as Medicaid eligibility is maintained. If the member is enrolled in a fee for service program on the date of admission, then the fee for service program is responsible for the entire hospital stay as long as Medicaid eligibility is maintained.

Pregnant Women receiving Medicaid are exempt from copays from the 1st day of pregnancy until the end of the month of the 60 day transitional period.

**Eligibility Verification Request**

Member ID  Birth Date   
Last Name  SSN   
First Name  From/Thru   
Date of Service   
Gender  Service Type  30 - Health Plan Benefit Coverage

**search**  
**clear**

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

**Eligibility Verification Request**

Member ID  111222333444 Birth Date   
Last Name  SSN   
First Name  From/Thru  09/30/20XX  
Date of Service  10/24/20XX  
Gender

**search**  
**clear**

**Member ID Information**

Member ID  111222333444 First Name  L.  
Birth Date  12/4/19XX Last Name  SMITH  
Address 1  123 ABC STREET Middle Initial  H.  
Address 2(County)  107 - NEWTON Name Suffix   
City  COVINGTON Gender  F  
State  GA Transaction Date/Time  10/03/20 02:54:59  
Zip  30016-2907 Confirmation #  122770010D

**Eligibility Spans**

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

**If 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:

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy  
Account | Providers | Training | Claims | **Eligibility** | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

Home | **Eligibility Request**

(click to hide) Alert Message posted 2  
This site is for testing purposes only!  
This site is for testing purposes only. Any information entered is for testing purposes only.

Newborn Activations  
Hospital Activations  
Pregnant Women Activations  
Women's Health Activations

User Information - Provider 000155933X

## The Hospital PE Screen will appear:

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

[submit](#) [cancel](#)

**Presumptive Eligibility for Hospital Request**

Household Information

Qualifying Member ID  
Net/Taxable Income\*

Number of Adults\*  
Number of Children\*

Member Information

Member ID  
First Name\*  
Last Name\*  
MI  
Suffix  
Race\*  
Citizenship\*  
Gender\*  
Birth Date\*  
SSN 000-00-0000  
Home Phone  
Other Phone  
Ethnicity\*  
Primary Household Language\*

Mailing Address

Address\*  
Address 2  
City\*  
Zip\* 00000 0000  
State\* GA  
County\*

Residential Address

Same as Mailing Address  
Address\*  
Address 2  
City\*  
Zip\* 00000 0000  
State\* GA  
County\*

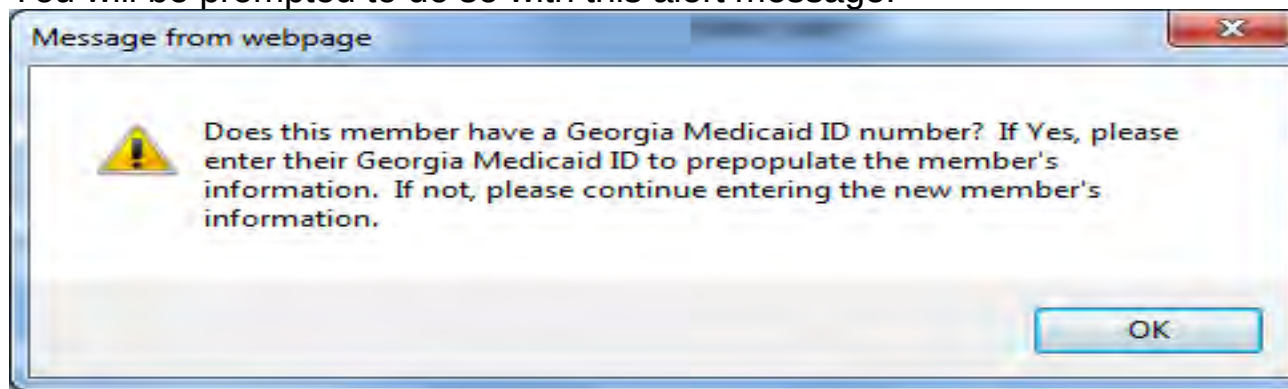
Eligibility Information

Medicaid Application Submitted?\*  
Is Member Pregnant?  
Number of Expected Births  
Application Date\*  
Pregnancy Due Date  
Determination/Eligibility Begin Date 03/16/2015

Denial Reason  
Aid Category

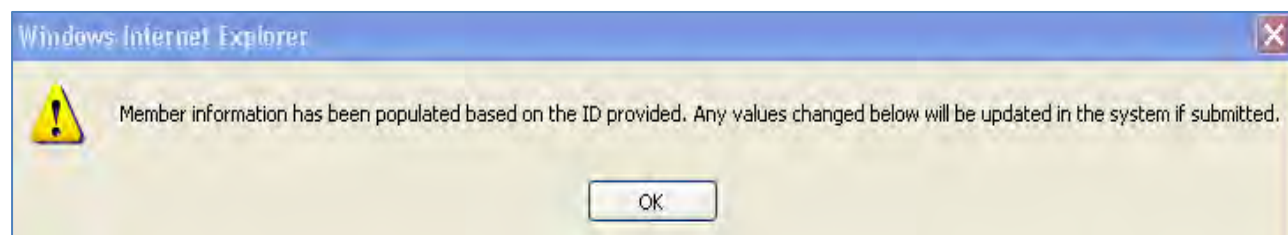
Enter the applicant's original ID number to auto-populate the fields on this panel.

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.

|                                             |                                         |                                                                                       |
|---------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------|
| <b>Application Date*</b>                    | <input type="text"/>                    |  |
| <b>Pregnancy Due Date</b>                   | <input type="text" value="09/23/2015"/> |  |
| <b>Determination/Eligibility Begin Date</b> | <input type="text" value="03/16/2015"/> |                                                                                       |

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

The following messages were generated:

The presumptive eligibility request was successfully processed. The Medicaid ID is 222113132824. Select the following link to open a [certificate of eligibility](#), if a window does not appear or if you close the initial certificate.

### Presumptive Eligibility for Hospital Request

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

**GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH**

**GEORGIA  
WEB PORTAL**

**GEORGIA  
HEALTH  
PARTNERSHIP**

Welcome, Search

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

**Temporary Member Identification Card**

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

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

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

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

A Division of Family and Children Services Medicaid Eligibility Specialist will contact the member about her eligibility. Rx BIN Number 003858

**Eligibility Verification Request**

From/Thru  
Date of Service 09/01/20 10/31/20

**Member ID Information**

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

**Eligibility Spans**

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

# Appendix I – Income

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

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

## 2499 – TREATMENT OF INCOME IN MEDICAL ASSISTANCE

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

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

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

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

**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)<br><b>E* (MAGI)</b><br><small>*Divorces and separations finalized/ modified before 1/1/2019, include Alimony as income for MAGI.</small> | I             |
| AMERICORPS               | Income from Americorps Network of programs which encompasses:<br><br>Americorps USA<br><br>Americorps VISTA<br><br>Americorps NCCC<br><br>Are handled as specified below:                                                                                                                                                  |                                                                                                                                                       |               |

**CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE**

| <b>TYPE OF INCOME</b>           | <b>DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION</b>                                                                                                                                                                                                                                                                                           | <b>ELIGIBILITY - FAMILY OR ABD</b> | <b>PLCS FOR ABD</b> |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------|
|                                 | Living Allowance Stipend – Earned Income                                                                                                                                                                                                                                                                                                       | E (Non MAGI)<br>I (MAGI)           | E                   |
|                                 | On-the Job Training – Earned Income                                                                                                                                                                                                                                                                                                            | E (Non MAGI)<br>I (MAGI)           | E                   |
| ANNUITY                         | Unearned – Recurring payment received from an investment. Refer to <a href="#">Section 2339</a> , 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)<br>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.<br><br>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)<br>I* (MAGI)<br>*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.<br><br>Consider the income as follows:<br><br>• Self-employment if the attendant provides child care services in his/her home<br><br>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 |
|                                                               | <p>unearned income.</p> <p>If the payment is for any other child, treat as self-employment income.</p> <p>Refer to the <a href="#">Section 3415</a>, Self-Employment.</p>                                                                                                                                                                                                                                                                   |                                                    |               |
| CHILD SUPPORT                                                 | <p>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.</p> <p>*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.</p>               | <p>I (ABD)</p> <p>E (MAGI)</p> <p>I (Non MAGI)</p> | I             |
| CHILD'S EARNINGS                                              | <p>Earned – Income earned by a child, including MAGI Medical Assistance under 19 years old and for CW-FC children to 21 years.</p> <p>*Refer to Section 2610 to determine when Child's Earnings should be counted.</p>                                                                                                                                                                                                                      | <p>I (ABD)</p> <p>E* (MAGI and Non MAGI)</p>       | E             |
| Children in Placement                                         | <p>Reference <a href="#">Section 2835</a>, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria for children in care.</p>                                                                                                                                                                                                                                                                                                          |                                                    |               |
| CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS | <p>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.</p> <p>Use notices or other documents in the individual's possession (other than a check) to verify the gross amount of</p> | <p>I (MAGI and Non MAGI)</p>                       | 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:<br><br>Office of Personnel Management<br>Retirement and Insurance Coverage<br>1900 E. Street, NW<br>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 <a href="#">Section 2653</a> , 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.<br><br>*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.<br><br>EXCEPTION: Never include ISM as income for an A/R in LA-D.                                                                                        | *I (ABD and Non MAGI)<br>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 |
|                                                      | <ul style="list-style-type: none"> <li>• Cash or in-kind gifts given by relatives, friends, or a community group to "help out" with expenses related to the death</li> <li>• Inheritances in cash or in kind</li> <li>• Lump sum death benefits from SSA</li> <li>• Proceeds of life insurance policies received due to the death of the insured</li> <li>• RR Retirement burial benefits</li> <li>• VA burial benefits</li> </ul> <p>NOTE: Recurring survivor benefits such as those received under Title II (RSDI), private pension programs, etc., are not death benefits.</p> <p>* 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.</p> <p>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.</p> <p>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.</p> |                             |               |

| 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                                        | <p>Unearned – A portion of income of a non- AU or BG member that is applied to the AU.</p> <p>* For ABD, there is no deeming in Patient Liability/Cost Share determinations.</p>                                                                                            | 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)<br>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)<br>I (MAGI) | E              |
| DIVERTED INCOME FOR FAMILY MEDICAL ASSISTANCE        | <p>Unearned – Money deducted or diverted by a court order to a third party.</p> <p>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.</p>                                         | E<br><br>I                       | N/A<br><br>N/A |
| Children in Placement                                | Benefits/support (child support, SSI, RSDI, etc.) of a child in care diverted to the county of custody as designated payee for the benefit and care of the child and are considered the child's benefits/support. Refer to specific type of income for treatment of income. |                                  | N/A            |
| DIVERTED INCOME FOR ABD MEDICAL ASSISTANCE           | <p>Unearned - Income diverted to a spouse or dependent family member from a NH or CCSP A/R.</p> <p>Include as unearned income to the spouse or dependent family member</p>                                                                                                  | I                                | I              |

| CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |               |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------|
| TYPE OF INCOME                                       | DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ELIGIBILITY - FAMILY OR ABD | PL/CS FOR ABD |
| A/R                                                  | <p>(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 <a href="#">Section 2554</a>. Diversion of Income.</p> <p>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.</p>                                                                                                                           | I                           | E             |
| DIVIDENDS                                            | <p>Unearned – A share of profits received by a policy holder or shareholder.</p> <p>NOTE: Any dividends left to accrue are a resource separate from the resource that is earning dividends.</p> <ul style="list-style-type: none"> <li>For ABD, any dividends earned on countable resources are not counted as income.</li> <li>For non-FBR COAs, dividends earned on excluded life insurance policies are excluded as income.</li> </ul> <p>*For Family, dividends earned on life insurance policies are a countable resource.</p> <p>NOTE: Non-participating life insurance policies do not earn/pay dividends. Use Form 106 or other acceptable documents to verify dividends.</p> | *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**

| <b>TYPE OF INCOME</b>                                                                            | <b>DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>ELIGIBILITY- FAMILY OR ABD</b> | <b>PLCS FOR ABD</b> |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------|
|                                                                                                  | <p>certain low income working taxpayers. This tax credit may or may not result in a payment.</p> <p>EITC payments can be received as an advance from an employer or a refund from IRS.</p> <p>EITC given as a tax credit (no payment) is not income.</p>                                                                                                                                                                                                                            |                                   |                     |
| <b>EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS</b><br>(Title IV of Higher Education Act Programs) | <p><b>UNEARNED-</b> 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.</p> <p>Unearned – payments from educational assistance to the A/R. Exclude, regardless of use.</p> | <b>E (ABD, MAGI and Non MAGI)</b> | <b>E</b>            |
| <b>EMERGENCY ASSISTANCE (IV-A)</b>                                                               | <p>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.</p> <p>NOTE: Georgia does not provide Emergency Assistance payments.</p>                                                                                                                                                                                                 | <b>I</b>                          | <b>I</b>            |
| <b>EMPLOYEE RETIREMENT BENEFITS</b>                                                              | <p>Unearned – Individuals/surviving spouse may be eligible for retirement benefits based on previous employment.</p> <p>Explore if the A/R or spouse worked 10 or more years for the same employer.</p>                                                                                                                                                                                                                                                                             | <b>I</b>                          | <b>I</b>            |
|                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                     |

| 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 <a href="#">Section 2415, Self-Employment</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 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.<br><br>Otherwise, contact the State Medical Assistance Unit for further instructions.                                                                                                                                                                                                                                                                                                                               | E                           | E             |
| FEDERAL PROGRAMS, MISCELLANEOUS                                                             | <ul style="list-style-type: none"> <li>• Federal Housing Assistance</li> <li>• Food Stamps</li> <li>• Food Programs with federal involvement for Older Americans</li> <li>• Refugee Cash Assistance, Cuban and Haitian</li> <li>• Entrant Cash Assistance and federally reimbursed general assistance payments to refugees</li> <li>• Refugee reception and placement grants and refugee matching grants</li> <li>• Relocation Assistance</li> </ul> <p>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.</p> | E                           | E             |

**INCOME****TREATMENT OF INCOME**

| <b>CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE</b> |                                                                                                                                                                                                                                                             |                                    |                      |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------|
| <b>TYPE OF INCOME</b>                                       | <b>DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION</b>                                                                                                                                                                                                        | <b>ELIGIBILITY - FAMILY OR ABD</b> | <b>PL/CS FOR ABD</b> |
| FLEXIBLE BENEFITS                                           | Earned – Refer to Wages in this chart.                                                                                                                                                                                                                      | I                                  | I                    |
| FOSTER CARE PAYMENTS (TV-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 (TV-E)                                 | Unearned – per diem payment received to provide for the needs of the foster child.<br><br>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*<br>FM-E                     | I                    |

**INCOME****TREATMENT OF INCOME**

| <b>CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE</b>        |                                                                                                                                                                                                                                                                                     |                                    |                      |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------|
| <b>TYPE OF INCOME</b>                                              | <b>DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION</b>                                                                                                                                                                                                                                | <b>ELIGIBILITY - FAMILY OR ABD</b> | <b>PL/CS FOR ABD</b> |
| 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.<br>*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.<br>*For ABD, do not deem GRG income of the A/R's parent or spouse to the A/R. | ABD-I*<br>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.<br>* 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).<br><br>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.).<br><br>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 1300, Resources, to determine how to count income tax refunds. For how to count in PL/CS, refer to <a href="#">Section 2552, PL/CS Deductions</a> .                                                                                                                                    | *                           | *                         |
| INDIAN LAND GRANTS                                   | Unearned – Federal distributions to members of Indian Tribes.                                                                                                                                                                                                                                                | E                           | E                         |
| INDIAN GAMBLING ACT PAYMENTS                         | Tribally managed gaming revenues<br><br>* 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.<br><br>Exclude expenses for the last illness & burial of the deceased if paid by the inheritor.<br><br>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)<br>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.<br><br>* Refer to <a href="#">Section 2430</a> , Living Arrangements and In-Kind Support and Maintenance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | *I (ABD)<br>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.<br><br>* Refer to <a href="#">Section 2230</a> , 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.<br><br>FAMILY: Annualize for prospectively budgeted AUs to determine a monthly amount.<br>*Exclude amounts of \$1.00 or less per month.<br><br>ABD: The following types of interest earned on countable resources are excluded as income in the eligibility and PL/CS budgets:<br><ul style="list-style-type: none"> <li>• Interest earned on all countable financial instruments, such as checking/savings accounts, CDs, etc.</li> <li>• Interest earned on countable Patient Fund Accounts.</li> </ul> *Exception: Interest portion of payment made on contracts are counted as income.<br><br>*NOTE: If total interest earned on excluded resources is \$20/month or | Family-*I<br>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 AMDN spenddown budgets. If total interest earned on excluded resources exceeds \$20/month, include all the interest in the eligibility and spenddown budgets. See exceptions below.               |                                     |                 |
| INTEREST                                             |                                                                                                                                                                                                                                                           |                                     |                 |
| Burial Contracts                                     | Exclude interest earned on the excluded portion of a burial contract for FBR A/Rs.                                                                                                                                                                        | E                                   | E               |
| Burial Funds                                         | Exclude all interest earned on a burial contract for non-FBR A/Rs if left to accrue.                                                                                                                                                                      | E                                   | E               |
|                                                      | Exclude interest earned on the excluded portion of funds set aside for burial for FBR A/Rs.                                                                                                                                                               | E                                   | E               |
|                                                      | Exclude interest earned on the first \$5000 of funds set aside for burial for non-FBR A/Rs if left to accrue.                                                                                                                                             | E                                   | E               |
| INTEREST                                             |                                                                                                                                                                                                                                                           |                                     |                 |
| Dividends                                            | Exclude interest earned on the dividend accumulations from excluded life insurance policies for ABD non-FBR A/Rs.                                                                                                                                         | E                                   | E               |
|                                                      | For Family, include interest earned on life insurance policies, stocks and mutual funds.                                                                                                                                                                  | I                                   | I               |
|                                                      | For ABD, exclude as income dividends/interest earned on countable resources such as stocks and mutual funds.                                                                                                                                              | E                                   | E               |
| IRREGULAR/<br>INFREQUENT<br>INCOME                   | Earned and Unearned – Income that is received too infrequently or irregularly to be anticipated, regardless of the amount. Refer to <a href="#">Section 2504</a> for definition of irregular or infrequent income.<br>Treat such income as the following: |                                     |                 |
|                                                      | <ul style="list-style-type: none"> <li>Earned income of \$30 or more received over a three month period</li> <li>Earned income of less than \$30 received over a three month period</li> </ul>                                                            | I<br><br>E-ABD<br>I-Family<br>E-ABD | I<br><br>I<br>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 |
|                                                                       | <ul style="list-style-type: none"> <li>Unearned income of less than \$60 received over a three-month period</li> </ul> <b>Unearned income of \$60 or more received over a three-month period</b>                                                                                                                                                                                                                                                  | I-Family<br><br>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 <a href="#">Section 2313</a> .                                                                                                                                                                                                                                                                     | I *                         | I*            |
| LOTTERY WINNINGS                                                      | Unearned – A sum of money received as a result of purchasing a winning ticket in a game of chance.<br><br>* Refer to the appropriate sections on Lump Sum budgeting for Family or ABD Medical Assistance.                                                                                                                                                                                                                                         | *                           | *             |
| LUMP SUM<br><br><br><br><br><br><br><br><br><br>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.<br>* 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).<br>For all AFDC related categories of Medical Assistance, a lump sum is treated as income in the month received and as a resource in any amounts thereafter. | *                           | *             |

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

**INCOME****TREATMENT OF INCOME**

| <b>CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE</b>  |                                                                                                                                                                                                                                                                                                                   |                                    |                      |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------|
| <b>TYPE OF INCOME</b>                                        | <b>DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION</b>                                                                                                                                                                                                                                                              | <b>ELIGIBILITY - FAMILY OR ABD</b> | <b>PL/CS FOR ABD</b> |
| Army                                                         | USAFAC<br>Director, Retired Operations<br>Indianapolis, IN 46246<br>ATTN: Management Support Office                                                                                                                                                                                                               |                                    |                      |
| Marine Corps                                                 | Parallel FO: D24<br>Marine Corps Finance Center<br>1500 E. 95th Street<br>Kansas City, MO 64197                                                                                                                                                                                                                   |                                    |                      |
| Navy                                                         | Parallel FO: D24<br>Retired Pay Department<br>Code 305, Navy Finance Center<br>Anthony J. Celebrezze Building<br>Cleveland, OH 44199                                                                                                                                                                              |                                    |                      |
| <b>MILITARY RETIREMENT LUMP SUM</b>                          | Unearned – Consider as unearned income in the month of receipt. Treat as a resource the month following the month of receipt.                                                                                                                                                                                     | I                                  | I                    |
| <b>MONTGOMERY GI BILL PAYMENTS</b>                           | 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.<br><br>NOTE: Any portion of funds that come from the individual's earnings is counted as income. | E                                  | E                    |
| <b>NATIONAL EMERGENCY GRANT (DISASTER RELIEF EMPLOYMENT)</b> | 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                    |
| <b>NATIONAL FLOOD INSURANCE PAYMENTS</b>                     | UNEARNED- Payments made for flood mitigation activities under the National Flood Insurance Act of 1968.                                                                                                                                                                                                           | E                                  | E                    |
| <b>NOISE ABATEMENT PAYMENTS</b>                              | Unearned – Non-recurring payment designated for noise abatement work on a dwelling.                                                                                                                                                                                                                               | E                                  | E                    |
| <b>OLDER AMERICANS ACT/ SENIOR COMMUNITY SERVICE</b>         | 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<br><br>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<br>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<br>ABD LA-D COAs – E<br>All other ABD COAs – N/A | I             |
| Qualified Tuition Savings Programs (529 Plans)                                                                                                                              | A savings plan for higher education<br>Refer to <a href="#">Section 2344</a> .                                                                                                                                                                                                                                                                                                                       | E                                                             | E             |
| RAILROAD RETIREMENT (RR)                                                                                                                                                    | Unearned – retirement, survivors or disability income paid to former railroad employees and /or their dependents.<br><br>Use gross RR and/or RSDI, including the amount paid as a Medicare premium.<br><br>* For ABD, refer to <a href="#">Section 2552</a> , 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)<br>(cont'd)                 | <p>share budget.</p> <p>Consider a benefit augmented for dependents as income to the beneficiary, not the dependent.</p> <p>If the A/R's SSN begins with a 7, the individual is likely to be eligible for RR.</p> <p>If the A/R's deceased spouse worked for a railway system, the A/R may be eligible, even if remarried.</p> <p>RSDI and RR may be combined in one check. If so, verify RSDI via SSA and RR through the Railroad Retirement Board.</p> <p>To obtain written verification of the benefit amount, complete Form 990 and mail to:</p> <p>Benefits Verification<br/>Railroad Retirement Board<br/>401 W. Peachtree Street, Room 1702<br/>Atlanta, GA 30365-2550</p> |                             |               |
| 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.<br>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                                                                                                        | <p>Earned or unearned – Money received on property owned by an AU member and rented to others.</p> <p>Earned – Must be engaged in management of property an average of 20 hours per week.</p> <p>Unearned – If not involved in management more than 20 hours per week.</p>                                                                                                                                                                                                      | I<br>Family-May deduct expenses from maintaining and handling of property | I<br>May deduct expenses from maintaining and handling of property |
| REPAYMENT OF OVERPAYMENT OF BENEFITS THROUGH BENEFIT REDUCTION IN TANF, SSI, RSDI, UCB (or others)                   | <p>FAMILY MEDICAID: Unearned – Money withheld from the income source to repay a previous overpayment.</p> <p>Do not count the repayment amount. Count the gross minus the repayment amount.</p> <p>* ABD, Refer to RSDI Recoupment Amount and SSI Recoupment Amount in this chart.</p>                                                                                                                                                                                          | FM – E<br>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) | <p>Unearned – Social Security benefits paid to an insured worker or dependent on the basis of the retirement, death or disability of the worker.</p> <p>Use the gross entitlement (before the Medicare Part B premium is deducted) in the eligibility budget.</p> <p>* For ABD, refer to <a href="#">Section 2552</a>, Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget.</p> | I (Non-MAGI)<br>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)<br>(Also referred to as TITLE II BENEFITS or Social Security Benefits)<br>(cont'd) | <p>Count the entire RSDI lump sum payment as income for the month of receipt.</p> <p>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.</p> <p>Do not count refunded Medicare Part B premiums as unearned income.</p> <p><b>*For MAGI COAs RSDI of a tax dependent/child who has no other source of income AND resides with a parent is <u>excluded</u>. RSDI for a tax dependent/child is countable <u>only</u> 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.</b></p> | I (Non-MAGI)<br>I* (MAGI)   | I*            |
| REVERSE MORTGAGE                                                                                                                    | <p>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.</p> <p>The HEC plans connected with HUD through the Federal Housing Authority are reverse mortgages.</p> <p>Treat as loan proceeds</p> <p>Annuity payments from a RAM</p>                                                                                                                                               |                             |               |

| 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                               | <p>Unearned – an amount withheld from an individual's monthly RSDI check by SSA to recover an overpayment of RSDI benefits to the individual</p> <p>*Refer to Repayment of Overpayment of Benefits on Page 2499-21.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>ABD – I</p> <p>FM – E*</p> | E                          |
| SALE – LEASEBACK                                     | <p>Unearned – the homeowner transfers title of the home to a buyer (e.g., an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. The difference between payments on the installment note and the rental cost provides the former homeowner with cash. Under this arrangement, the buyer is responsible for the payment of real estate taxes, major maintenance, and casualty insurance. Some sale-leaseback arrangements involve the purchase of an annuity.</p> <p>Treat as the conversion of a resource, not as income.</p> <p>Interest earned from an installment note</p> <p>Annuity payments</p> | <p>E</p> <p>I</p> <p>I</p>    | <p>E</p> <p>I</p> <p>I</p> |
| 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 <a href="#">Section 2415, Self-Employment</a> .                                                                                                                                                                                                                                                                                                                 |                             |               |
| 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.<br>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.<br><br>Consider UNEARNED income for Family Medical Assistance.<br><br>Refer to <a href="#">Section 2430, In-Kind Support and Maintenance</a> , 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.<br><br>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<br><br>I                  | I             |

**INCOME****TREATMENT OF INCOME**

| <b>CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                    |                      |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------|
| <b>TYPE OF INCOME</b>                                       | <b>DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>ELIGIBILITY - FAMILY OR ABD</b> | <b>PL/CS FOR ABD</b> |
| SICK PAY<br>(cont'd)                                        | Earned – If paid from employer's payroll.<br><br>Unearned – Paid by insurance company or a source other than an employer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | I<br><br>E (MAGI)<br>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.<br><br>* 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.<br>** Refer to <a href="#">Section 2578</a> , SSI Recipients, for information on including SSI income in nursing home patient liability budgets. | ABD-*I<br>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<br>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 |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------|
|                                                       | <ul style="list-style-type: none"> <li>Exclude a SSI recoupment from a SSI check, but include a SSI recoupment from an RSDI check, in the patient liability budget.</li> </ul> <p>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.</p> |                               |               |
| SUSAN WALKER VS BAYER CORPORATION SETTLEMENT PAYMENTS | <p>A cash settlement as a result of a class action lawsuit.</p> <p>Unearned</p>                                                                                                                                                                                                                                                                 | E                             | E             |
| TAX REFUNDS                                           | <p>A refund of taxes paid on food, income or property. It may be considered as earned or unearned.</p>                                                                                                                                                                                                                                          | E                             | *             |
| Earned                                                | A refund of federal or state taxes paid on income.                                                                                                                                                                                                                                                                                              | E                             | *             |
| Unearned                                              | <p>A refund of taxes paid on food or property, such as real property or automobiles.</p> <p>Refer to <a href="#">Section 2405</a>, Treatment of Income.</p> <p>* Refer to <a href="#">Section 2552</a>, PL/CS Deductions.</p>                                                                                                                   | E                             | *             |
| TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)        | <p>Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments.</p> <p>TANF benefits received from another state are budgeted for the month of receipt only.</p> <p>*For ABD, do not deem TANF income of the A/R's parent or spouse to the A/R.</p>                                               | <p>ABD – I*</p> <p>FM - E</p> | 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<br>(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.<br><br>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.<br>*For ABD, do not deem WSP income of the A/R's parent or spouse to the A/R. | ABD-I*<br>FM-E              | I             |
| TRUST FUND PROCEEDS                                                         | Unearned – Money in a trust fund.<br><br>* 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<br>(cont'd)                                             | * If the trust is an MQT, refer to <a href="#">Section 2336</a> , Trust, Medicaid Qualifying, for information on how to treat the trust proceeds.<br><br>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 AED | PL/CS FOR AED |
|                                                      | 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.<br><br>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.<br><br>NOTE: For ABD, consider possibility of ISM. Refer to <a href="#">Section 2430</a> . |                             |               |
| VETERANS ADMINISTRATION (VA) BENEFITS                                               | Refer to <a href="#">Section 2418</a> – VA Income for a description of the different types of VA income.                                                                                                 |                             |               |
| VA PENSION                                                                          | Unearned<br><br>VA pensions are IBON and are not entitled to the \$20 general exclusion. (Section 2505)                                                                                                  | ABD-I<br>FM-E               | I             |
| VA COMPENSATION                                                                     | Unearned<br><br>VA compensation is not IBON.<br><br>EXCEPTION: Compensation received by parents due to the service connected death of their child is IBON.                                               | ABD-I<br>FM-E               | I             |
| VA EDUCATIONAL BENEFITS                                                             | Unearned                                                                                                                                                                                                 | ABD – I<br><br>FM – E       | E             |
| Other VA Benefits Which are NOT Included As Income in the Eligibility Determination | Aid and Attendance                                                                                                                                                                                       | E                           | E             |
|                                                                                     | Unusual Medical Expense (UME) reimbursement & Continuing Medical Expense (CME)                                                                                                                           | E                           | E             |
|                                                                                     | Housebound Allowance                                                                                                                                                                                     | E                           | E             |
|                                                                                     | Clothing Allowance                                                                                                                                                                                       | E                           | E             |
| Augmented VA Benefits                                                               | Unearned<br><br>*Refer to <a href="#">Section 2418</a> VA Income for specifics on counting Augmented VA income.<br><br>NOTE: Any portion of a VA check augmented for dependents is income to             | ABD-*I<br>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<br>To NH/CCSP A/Rs             | Unearned<br><br>* Refer to <a href="#">Section 2418</a> . VA Income for specifics on counting Augmented VA income for LA-D A/Rs.<br><br>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<br>FM-E                                                    | *I                                    |
| VA Recoupment                                        | Repayment of VA benefits which are deducted from the VA check.                                                                                                                                                                                                                                   | I<br>Count the gross amount for eligibility determination<br>FM-E | E<br>Count the gross less recoup-ment |
| VA Lump Sum                                          | Unearned<br><br><ul style="list-style-type: none"> <li>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.</li> </ul>                                                        | ABD-*I<br>FM-E                                                    | *I                                    |
| VICTIM RESTITUTION                                   | Unearned – Money received by a victim of a crime from a crime victim restitution program, usually a reimbursement for financial losses.                                                                                                                                                          | E                                                                 | E                                     |
|                                                      | <ul style="list-style-type: none"> <li>The value of the payment does not exceed the value of the loss.</li> </ul>                                                                                                                                                                                | E                                                                 | E                                     |
|                                                      | <ul style="list-style-type: none"> <li>The value of the payment exceeds the value of the loss. Count the excess value as income in the month of receipt.</li> </ul>                                                                                                                              | I                                                                 | I                                     |
| VICTIM RESTITUTION<br>(cont'd)                       |                                                                                                                                                                                                                                                                                                  |                                                                   |                                       |

| CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE                          |                                                                                                                                                                                                                                                                                                                                                                                                 |                             |                   |
|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------|
| TYPE OF INCOME                                                                | DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION                                                                                                                                                                                                                                                                                                                                                   | ELIGIBILITY - FAMILY OR ABD | PL/CS FOR ABD     |
|                                                                               | <ul style="list-style-type: none"> <li>The payment is a set monthly amount based on a court ruling. Count as income in the month of receipt.</li> </ul>                                                                                                                                                                                                                                         | 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<br>RSVP Foster Grandparent/<br>VISTA Urban Crime Prevention | <p>Unearned – Title II of Domestic Volunteer Services Act of 1973</p> <p>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.</p>                                                                                                                                                      | <p>E</p> <p>E</p>           | <p>I</p> <p>I</p> |
| WAGES (SALARIES)<br><br>Children in Placement                                 | <p>Earned – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis.</p> <p>Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee's share of FICA when paid by the employer. Reference <a href="#">Section 2835, PROCEDURES</a>, Earnings of an AFDC Child, for exclusion criteria.</p> | I                           | I                 |
| WORKER'S COMPENSATION                                                         | <p>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.</p> <p>Verify from the employer or from the source of the payment.</p>                                                                                               | ABD-I<br>FM-E               | I                 |
| WORKFORCE INVESTMENT ACT                                                      | Earned – Income received while working as part of a WIA program.                                                                                                                                                                                                                                                                                                                                | I                           | I                 |

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

|                                  |                                                                                                                                                                                                                                                                                                                                                          |                |     |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----|
| WORK STUDY PROGRAM (Federal)     | Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.                                                                                                                                                                                                                        | E              | N/A |
| WORK STUDY PROGRAM (Non-Federal) | Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.                                                                                                                                                                                                                        | I              | N/A |
| WORK SUPPORT PAYMENTS (WSP)      | A time limited cash supplement to a TANF assistance unit that, because of employment, either becomes ineligible for TANF or experiences a reduction in its TANF benefit amount and declines ongoing TANF in order to stop the TANF clock.<br>*For ABD, do not deem WSP income of the A/R's parent or spouse to the A/R.                                  | ABD-I*<br>FM-E | I   |
| YOUTH BUILD PROGRAM PAYMENTS     | EARNED- Payments made through the Youth Build Program.<br><br>*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: <ul style="list-style-type: none"> <li>• Youth incentive entitlement pilot project</li> <li>• Youth community conservations and improvement projects</li> <li>• Youth employment</li> </ul> *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                  |
| 8/25/23  | Ukrainian Nationals Policy                                                                  |
| 2/3/23   | Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2023                  |
| 2/7/24   | Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2024                  |



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | [www.dch.georgia.gov](http://www.dch.georgia.gov)

February 20, 2015

**MEMORANDUM**

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

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

**RE:** Presumptive Eligibility Medicaid Federal Poverty Levels for 2015

The purpose of this memorandum is to inform Qualified Providers (QP) of the Presumptive Eligibility (PE) Medicaid Federal Poverty Levels (FPL) for 2015. The following federal poverty level and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2015 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. Please use these income limits in processing presumptive eligibility effective April 1, 2015.

PE Pregnant Women Medicaid FPL at 220% effective April 1, 2015

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

Add \$763 to the net income limit, and \$17 to the deduction, for any additional individual(s) added

Women's Health Medicaid (WHM) remains at 200% of the Federal Poverty Level. Please use this income limit chart effective April 1, 2015.

| <b>Budget<br/>Group</b> | <b>200%<br/>FPL</b> |
|-------------------------|---------------------|
| 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



March 4, 2015

**MEMORANDUM**

**TO:** Dr. Seema Czukas, 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@dcl.ca.gov](mailto:awashington1@dcl.ca.gov), Program Consultant at 404-857-7263.

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



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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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 *YJG*  
DCH Medicaid Eligibility & Policy

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

### **Question:**

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

### **Response:**

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

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

Please note we do not count resources in MAGI.

Ginger Henry  
Page 2  
July 9, 2015

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

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



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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## MEMORANDUM

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

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

**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.

| Income Category |        | Children 0-18 |        | Children 19-24 |        | Children 25-64 |        | Children 65+ |        | Total  |        | Total  |        |
|-----------------|--------|---------------|--------|----------------|--------|----------------|--------|--------------|--------|--------|--------|--------|--------|
| Category        | Income | Income        | Income | Income         | Income | Income         | Income | Income       | Income | Income | Income | Income | Income |
| 1               | 310    | 50            | 360    | 1317           | 1367   | 1476           | 1526   | 2030         | 2080   | 2178   | 2228   | 2444   | 2494   |
| 2               | 457    | 67            | 524    | 1776           | 1843   | 1990           | 2057   | 2737         | 2804   | 2937   | 3004   | 3298   | 3365   |
| 3               | 551    | 84            | 635    | 2233           | 2319   | 2504           | 2588   | 3444         | 3528   | 3696   | 3780   | 4150   | 4234   |
| 4               | 653    | 102           | 755    | 2694           | 2796   | 3018           | 3120   | 4152         | 4254   | 4455   | 4557   | 5002   | 5104   |
| 5               | 752    | 119           | 871    | 3153           | 3272   | 3532           | 3651   | 4859         | 4978   | 5214   | 5333   | 5854   | 5973   |
| 6               | 826    | 136           | 962    | 3611           | 3747   | 4046           | 4182   | 5566         | 5702   | 5973   | 6109   | 6707   | 6843   |
| 7               | 903    | 154           | 1057   | 4072           | 4226   | 4561           | 4715   | 6276         | 6430   | 6735   | 6889   | 7561   | 7715   |
| 8               | 970    | 171           | 1141   | 4533           | 4704   | 5078           | 5249   | 6987         | 7158   | 7498   | 7669   | 8418   | 8589   |
| 9               | 1034   | 188           | 1222   | 4995           | 5183   | 5595           | 5783   | 7698         | 7886   | 8262   | 8450   | 9275   | 9463   |
| 10              | 1113   | 206           | 1319   | 5455           | 5661   | 6111           | 6317   | 8408         | 8614   | 9023   | 9229   | 10,130 | 10,336 |
| 11              | 1194   | 223           | 1417   | 5916           | 6139   | 6628           | 6851   | 9119         | 9342   | 9786   | 10,009 | 10,987 | 11,193 |
| 12              | 1244   | 240           | 1484   | 6378           | 6618   | 7145           | 7385   | 9830         | 10,070 | 10,550 | 10,790 | 11,844 | 12,084 |

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

Equal Opportunity Employer

Carrie Summers  
Page 2  
March 11, 2016

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

| <b>Budget<br/>Group</b> | <b>200%<br/>FPL</b> |
|-------------------------|---------------------|
| 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



August 21, 2014

## MEMORANDUM

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

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

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

### BACKGROUND

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

### PURPOSE

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

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

**Jonathan Duttweiler**  
**Page 2**  
**August 21, 2014**

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

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

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

**Note:** RSDI does NOT count toward the unearned threshold.

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

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

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



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

## MEMORANDUM

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

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

DATE: July 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.



Ginger Henry

Page 2

July 7, 2016

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](mailto:ygreene@dch.ga.gov) or Jonathan Duttweiler at 404-651-9981 or [jduttweiler@dch.ga.gov](mailto: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



Section 2269 - 1

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**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | [www.dch.georgia.gov](http://www.dch.georgia.gov)  
**MEMORANDUM**

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

**FROM:** Yvonne Greene, Sr. Manager, Business Operations *Yvonne*  
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)

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

Equal Opportunity Employer



Carrie Summers  
Page 2  
February 20, 2017

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](mailto: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



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

*YGG*

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)



Carrie Summers  
Page 2  
February 19, 2018

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](mailto:Kunita.snead@dch.ga.gov).

cc: Blake Fulenwider, Chief, Medical Assistance Plans  
Lynette Rhodes, Associate Chief, Medical Assistance Plans  
Jonathan Duttweiler, Assistant Chief, Member Services & Policy  
Ann Carter, Operations Director, DHS Office of Family Independence  
Jewel McKeever, Field Operations Director, DHS Office of Family Independence  
Kristen Hernandez, Right from the Start Medical Assistance Group Director  
Tara Dickerson, Deputy General Counsel  
Malcolm Wells, Director, Medicaid Legal Services  
Wesley Merritt, Quality Control Program Director 2  
Sheila Alexander, Sr. Manager, Business Operations, PeachCare for Kids®  
Barbara Vance, Myers and Stauffer



Nathan Deal, Governor

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 Sneed at 404-463-6234 or [Kunita.sneed@dch.ga.gov](mailto:Kunita.sneed@dch.ga.gov).

cc: Blake Fulenwider, Chief, Medical Assistance Plans  
Lynette Rhodes, Associate Chief, Medical Assistance Plans  
Jonathan Dunweller, Assistant Chief, Member Services & Policy  
Ann Carter, Operations Director, DHS Office of Family Independence  
Jewel McKeever, Field Operations Director, DHS Office of Family Independence  
Kristen Hernandez, Right from the Start Medical Assistance Group Director  
Tara Dickerson, Deputy General Counsel  
Malcolm Wells, Director, Medicaid Legal Services  
Wesley Merritt, Quality Control Program Director 2  
Barbara Vance, Myers and Stauffer



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](mailto:Kunita.Snead@dch.ga.gov) or 404-463-623 or Yvonne Greene at [ygreene@dch.ga.gov](mailto: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



Brian P. Kemp, 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 *Yvonne Greene*

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2019

DATE: February 20, 2019

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

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

For each additional person over Budget Group size 12:

Add \$19 (5% Deduction)  
Add \$50 (Parent/Caretaker with Children under 19)  
Add \$490 (133% FPL)  
Add \$549 (149% FPL)  
Add \$755 (205% FPL)  
Add \$811 (220% FPL)



Carie Summers  
Page 2  
February 20, 2019

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

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

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

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



September 24, 2019

**MEMORANDUM**

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

FROM: Anika Washington, Eligibility Policy Manager *AD for NW*  
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.



Bradly Green  
Tax Cuts and Jobs Act of 2017/Bipartisan Budget Act of 2018  
Page 2  
September 24, 2019

\*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](mailto:Kunita.Snead@dch.ga.gov) or 404-463-6234 or Anika Washington at [awashington1@dch.ga.gov](mailto: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



Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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**MEMORANDUM**

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

FROM: Anika Washington, Eligibility Policy Manager *AW*  
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)



Carie Summers  
Page 2  
February 19, 2020

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](mailto: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



## MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager *AD*  
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)



Carie Summers  
Page 2  
February 19, 2021

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](mailto: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



TO: Bradley S. Green, Medicaid Unit Manager  
DFCS Office of Family Independence

FROM: Anika Washington, Eligibility Policy Manager <sup>ADW</sup>  
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.



Bradly S. Green

Page 2

July 16, 2021

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](mailto: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



## MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager *CAB 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](mailto:Kunita.snead@dch.ga.gov) or Teresa Fair at 404-651-9978 or [Teresa.fair@dch.ga.gov](mailto: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  
Karen Salter, Myers and Stauffer



## MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager *CRB for AH*  
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)



Carie Summers  
Page 2  
February 18, 2022

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](mailto:Kunita.snead@dch.ga.gov) or Teresa Fair at 470-727-7207 or [Teresa.fair@dch.ga.gov](mailto: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



**TO:** Bradly S. Green, Medicaid Unit Manager  
DFCS Office of Family Independence

**FROM:** Anika Washington, Eligibility Policy Manager <sup>(D)</sup>  
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 Kids® 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.



Bradly S. Green

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August 25, 2022

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](mailto: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



**MEMORANDUM**

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

FROM: Anika Washington, Eligibility Policy Manager <sup>AKW</sup>  
DCH Policy, Compliance and Operations Office

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2023

DATE: February 3, 2023

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2023 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) 2023 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, 2023.

| 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            | 61           | 310                                         | 1,616              | 1,811             | 2,491             | N/A      |
| 2            | 83           | 457                                         | 2,186              | 2,449             | 3,369             | 3,616    |
| 3            | 104          | 551                                         | 2,756              | 3,087             | 4,247             | 4,558    |
| 4            | 125          | 653                                         | 3,325              | 3,725             | 5,125             | 5,500    |
| 5            | 147          | 752                                         | 3,895              | 4,364             | 6,004             | 6,443    |
| 6            | 168          | 826                                         | 4,465              | 5,002             | 6,882             | 7,385    |
| 7            | 190          | 903                                         | 5,035              | 5,640             | 7,760             | 8,327    |
| 8            | 211          | 970                                         | 5,604              | 6,278             | 8,638             | 9,270    |
| 9            | 233          | 1,034                                       | 6,174              | 6,917             | 9,516             | 10,212   |
| 10           | 254          | 1,113                                       | 6,744              | 7,555             | 10,394            | 11,154   |
| 11           | 275          | 1,194                                       | 7,313              | 8,193             | 11,271            | 12,096   |
| 12           | 297          | 1,244                                       | 7,883              | 8,831             | 12,150            | 13,039   |

For each additional person over Budget Group size 12:

Add \$22 (5% Deduction)

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

Add \$570 (133% FPL)

Add \$639 (149% FPL)

Add \$879 (205% FPL)

Add \$943 (220% FPL)



Carie Summers

Page 2

February 3, 2023

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

| Budget Group | 200% WHM |
|--------------|----------|
| 1            | 2,430    |
| 2            | 3,287    |
| 3            | 4,144    |
| 4            | 5,000    |
| 5            | 5,857    |
| 6            | 6,714    |
| 7            | 7,570    |
| 8            | 8,427    |
| 9            | 9,284    |
| 10           | 10,140   |
| 11           | 10,996   |
| 12           | 11,854   |

For each additional person over Budget Group size 12 add \$857

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 Teresa Fair at 470-727-7207 or [Teresa.fair@dch.ga.gov](mailto:Teresa.fair@dch.ga.gov).

cc: Lynnette Rhodes, Executive Director, Medical Assistance Plan  
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office  
Rebecca Dugger, Deputy Executive Director, Eligibility and Enrollment Office  
Melonie Wilson, Director, Quality Control  
Tara Dickerson, Interim General Counsel  
Malcolm Wells, Director, Medicaid Legal Services  
Stefanie Ashlaw, Director, PeachCare for Kids®  
Karen Salter, Myers and Stauffer



## MEMORANDUM

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

**FROM:** Anika Washington, Interim Policy Administration Director <sup>(D)</sup>  
DCH Policy, Compliance and Operations Office

**RE:** Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2024

**DATE:** February 7, 2024

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2024 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) 2024 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, 2024.

| 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            | 63           | 310                                         | 1,670              | 1,870             | 2,573             | N/A      |
| 2            | 86           | 457                                         | 2,266              | 2,538             | 3,492             | 3,748    |
| 3            | 108          | 551                                         | 2,862              | 3,206             | 4,411             | 4,734    |
| 4            | 130          | 653                                         | 3,458              | 3,874             | 5,330             | 5,720    |
| 5            | 153          | 752                                         | 4,055              | 4,543             | 6,250             | 6,707    |
| 6            | 175          | 826                                         | 4,651              | 5,211             | 7,169             | 7,693    |
| 7            | 198          | 903                                         | 5,247              | 5,879             | 8,088             | 8,679    |
| 8            | 220          | 970                                         | 5,844              | 6,547             | 9,007             | 9,666    |
| 9            | 243          | 1,034                                       | 6,440              | 7,215             | 9,926             | 10,652   |
| 10           | 265          | 1,113                                       | 7,036              | 7,883             | 10,845            | 11,638   |
| 11           | 287          | 1,194                                       | 7,632              | 8,551             | 11,764            | 12,625   |
| 12           | 310          | 1,244                                       | 8,229              | 9,219             | 12,683            | 13,611   |

For each additional person over Budget Group size 12:

Add \$23 (5% Deduction)

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

Add \$597 (133% FPL)

Add \$669 (149% FPL)



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

Carie Summers  
Page 2  
February 7, 2024

Add \$920 (205% FPL)  
Add \$987 (220% FPL)

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

| Budget Group | 200% WHM |
|--------------|----------|
| 1            | 2,510    |
| 2            | 3,407    |
| 3            | 4,304    |
| 4            | 5,200    |
| 5            | 6,097    |
| 6            | 6,994    |
| 7            | 7,890    |
| 8            | 8,787    |
| 9            | 9,684    |
| 10           | 10,580   |
| 11           | 11,477   |
| 12           | 12,374   |

For each additional person over Budget Group size 12 add \$897

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 Teresa Fair at 470-727-7207 or [Teresa.fair@dch.ga.gov](mailto:Teresa.fair@dch.ga.gov).

cc: Stuart Portman, Executive Director, Medical Assistance Plans  
Lynnette Rhodes, Chief Health Policy Officer  
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office  
Rebecca Dugger, Deputy Executive Director, Eligibility and Enrollment Office  
Maxine Elliot, Deputy Executive Director, Service, Delivery & Administration Office  
Melonie Wilson, Director, Quality Control  
Tara Dickerson, Deputy General Counsel  
Malcolm Wells, Director, Medicaid Legal Services  
Stefanie Ashlaw, Director, PeachCare for Kids®  
Emily Wale, Myers and Stauffer  
J Tasch, 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:

|                                                                                                                                                                                                      |                                                                                                                                                                                                    |                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <p>Amerigroup Community Care<br/>1-800-454-3730<br/><a href="http://www.amerigroup.com">www.amerigroup.com</a></p> |  <p>Peach State Health Plan<br/>866-874-0633<br/><a href="http://www.pshpgeorgia.com">www.pshpgeorgia.com</a></p> |  <p>CareSource<br/>1-855-202-1058<br/><a href="http://www.caresource.com">www.caresource.com</a></p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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](http://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 (DHACS)                              |
| 871 | RSM (DHACS)                                  |
| 876 | RSM Pregnant Women (DHACS)                   |
| 894 | RSM Exp Pregnant Women (DHACS)               |
| 895 | RSM Exp Child < 1 (DHACS)                    |
| 897 | RSM Pregnant Women Income > 185% FPL (DHACS) |
| 898 | RSM Child < 1 Mother has Aid = 897 (DHACS)   |
| 918 | LIM Adult                                    |
| 919 | LIM Child                                    |
| 920 | Refugee Adult                                |
| 921 | Refugee Child                                |

**Excluded Categories of Eligibility (COE):**

| COE | DESCRIPTION                             |
|-----|-----------------------------------------|
| 124 | Standard Filing Unit – Adult            |
| 125 | Standard Filing Unit – Child            |
| 131 | Child Welfare Foster Care               |
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|     |                                       |
|-----|---------------------------------------|
| 225 | Pickle – Blind                        |
| 226 | Pickle – Disabled                     |
| 227 | Disabled Adult Child - Aged           |
| 227 | Disabled Adult Child - Aged           |
| 229 | Disabled Adult Child – Disabled       |
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| 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                    |
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| 255 | Cystic Fibrosis Waiver                |
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| 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 |
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| 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<br>(general information)<br><a href="http://www.amerigroup.com">www.amerigroup.com</a> | 1-855-202-1058<br><a href="http://www.careSource.com/Georgia">www.careSource.com/Georgia</a><br><a href="#">Medicaid</a> | 866-874-0633 (general information)<br>866-874-0633 (claims)<br>800-704-1483 (medical management)<br><a href="http://www.pshpgeorgia.com">www.pshpgeorgia.com</a> |

### 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](http://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](http://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<sup>o</sup> 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                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Amerigroup runs claims cycles twice each week (on Monday and Thursday) for clean claims that have been adjudicated.</p> <p>Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday.</p> <p>Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday.</p> <p>Dental: Checks are mailed weekly on Thursday for clean claims.</p> <p>Vision: Checks are mailed weekly on Wednesday for clean claims (beginning June 7th)</p> <p>Pharmacy: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)</p> | <p>CareSource runs claims cycles twice each week on Saturdays and Tuesdays for <u>clean</u> claims that have been adjudicated.</p> <p><u>Pharmacy:</u> Payment cycles for pharmacies is weekly on Wednesdays.</p> | <p>Peach State has two weekly claims payment cycles per week that produces payments for clean claims to providers on Monday and Wednesday.</p> <p>For further information, please refer to the Peach State website, or the Peach State provider manual.</p> |

**How often can a patient change his/her PCP?**

| Amerigroup Community Care | CareSource                                                                                                                                                                                                                                                                                                                          | Peach State Health Plan                                                                                                                                                                                                                                                                 |
|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Anytime                   | <p>Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as:</p> <ul style="list-style-type: none"><li>• Member requests to be assigned to a family member's PCP</li><li>• PCP does not provide the covered services a member seeks</li></ul> | <p>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.</p> |

|  |                                                                    |  |
|--|--------------------------------------------------------------------|--|
|  | due to moral or religious objections<br>• 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 24 <sup>th</sup> day of the month and are effective for the current month. PCP changes made after the 24 <sup>th</sup> 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<br><a href="https://providers.amerigroup.com/pages/ga-2012.aspx">https://providers.amerigroup.com/pages/ga-2012.aspx</a> | 844-441-8024<br><a href="https://cvs.az1.qualtrics.com/ife/form/SV_cvyY0ohqT2VXYod">https://cvs.az1.qualtrics.com/ife/form/SV_cvyY0ohqT2VXYod</a> | 866-874-0633<br><a href="http://www.pshpgeorgia.com">www.pshpgeorgia.com</a> |

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](http://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<br>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     | <b>Southeastrans</b><br><br><i>Toll free</i><br>1-866-388-9844<br><br><i>Local</i><br>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   | <b>Southeastrans</b><br>404-209-4000<br><br><i>Note: For Georgia Families 360°</i><br><br>1-866-991-6701                                                                                                                       | Fulton, DeKalb, and Gwinnett                                                                                                                                                                                                                                                                                                                                                                                                           |
| Central   | <b>ModivCare</b><br><b>(formerly LogistiCare)</b><br><br><i>Toll free</i><br>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      | <b>ModivCare</b><br><b>(formerly LogistiCare)</b><br><br>Toll free<br>1-888-224-7988<br><br><i>Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities</i><br><br>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 | <b>ModivCare</b><br><b>(formerly LogistiCare)</b><br><br>Toll free<br>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**

## **Just had a baby? Rolling off Pregnancy Medicaid?**

### **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](https://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 (P4HB)**

# Be Smart. Plan Before You Start!

## HOW DO I APPLY?

You can apply online at: [gateway.ga.gov](https://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)**

## How to order *Understanding Medical Assistance* booklets:

### Web Access

- Go To:  
<https://www.mmis.georgia.gov>  
Member Information tab and then to the Member Notification tab.



### Member Information Tab:



Refresh session | You have approximately 18 minutes until your session will expire. Wednesday, October 04, 2017

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

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

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

**User Information**  
Login/Manage Account Login

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NOTE: If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. Click here to obtain the latest version of the free Adobe Reader.

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**Member Notices (10 rows returned)**

| Title                                                             | File Type | Size (KB) | Release Date |
|-------------------------------------------------------------------|-----------|-----------|--------------|
| Understanding Medical Assistance                                  | PDF       | 102.8     | 10/03/2017   |
| Georgia Families Frequently Asked Questions and Answers - Members | PDF       | 446.5     | 09/06/2017   |
| ID#-B Important Notice                                            | PDF       | 74.4      | 01/25/2016   |
| Home and Community Services Booklet 2016                          | PDF       | 2446.7    | 01/21/2016   |
| Home and Community Services Booklet 2014                          | PDF       | 467.3     | 03/21/2014   |
| New co-payments for Prescribers for RDA                           | PDF       | 98.5      | 02/21/2012   |
| Form 5459 - Member's Release of Information                       | PDF       | 29.6      | 03/09/2011   |
| Fullford Release Submission Package                               | PDF       | 33.3      | 03/09/2011   |
| Home and Community Services Booklet                               | PDF       | 8866.7    | 12/27/2010   |
| Health Check Brochure                                             | PDF       | 1890.3    | 10/26/2010   |

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## Web Print

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

[https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/MEMBER%20NOTICES/medical%20assistance%20plans%20booklet%20%20final\\_e%2020171003130824.pdf](https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/MEMBER%20NOTICES/medical%20assistance%20plans%20booklet%20%20final_e%2020171003130824.pdf)

OR

[www.dch.ga.gov](http://www.dch.ga.gov)

Select Medicaid

Select Medicaid Publications from the left column

Under related Files Select “Medical Assistance Plans booklet”



## DMA 292 (Request for Forms)

- Download form DMA 292 from the web:

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy  
Home | Provider Notices | Provider Manuals | Provider Messages | Fee Schedules | Forms | PASRR Request | TPL Claims | FAQ for Providers  
Web Portal Training | Provider Education

User Information  
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PDF Reader Required  
NOTE: If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. [Click here to obtain the latest version of the free Adobe Reader.](#)

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| Forms (57 rows returned)                                     |            |           |              |
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| NR Submittal Form                                            | ENROLLMENT | 308.20    | 01/10/2011   |
| Form 1449 - Member's Release of Information                  | ALL FORMS  | 22.00     | 02/03/2011   |
| Interim Provider Payment Request Form                        | CLAIMS     | 31.90     | 02/03/2011   |
| Medicaid-PeachCare for Kids Provider Information Change Form | ENROLLMENT | 30.50     | 02/16/2011   |
| DMA 292 Request for Forms as Handbooks                       | ALL FORMS  | 70.60     | 03/01/2011   |

## Mail DMA 292 Form

- Mail form DMA 292 to:

Gainwell Technologies  
P. O. box 105209  
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HP will ship within five (5) business days. Order any quantity you need; each box can contain 400 booklets maximum.

