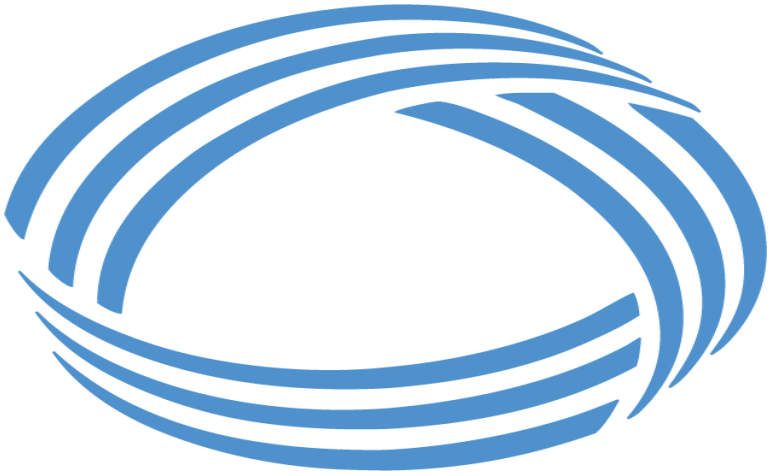
PART II

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

Version Date: January 1, 2026

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Policy Revision Record
from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
01/01/2026	Section 205	Revision to the description of training procedures.		
10/01/2025	N/A	No changes were made this quarter.	N/A	
8/28/2025	N/A	No changes were made this quarter.	N/A	
7/1/2025	N/A	No changes were made this quarter.	N/A	
4/1/2025	N/A	No changes were made this quarter.	N/A	

[1] The revisions outlined in this Table are from April 2025 to current. For revisions prior to 2025, please see prior versions of the policy.

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:

101.1. Understand Medical Assistance coverage available to individuals eligible for Medical Assistance

101.2. Understand the application process for PE;

101.3. Understand the eligibility requirements to be used in making PE determinations;

101.4. Be able to compute a PE budget using a PE Hospital application form 632H;

101.5. To screen on Georgia Medicaid Management Information System (GAMMIS) to prevent multiple Medical Assistance ID numbers being issued;

101.6. To correctly perform on-line entry of the PE Medical Assistance application;

101.7. Understand procedures for processing Medical Assistance applications.

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

Note: 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

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.

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 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.

201.1. A Qualified Hospital is a hospital that:

201.2. Participates as a Georgia Medical Assistance provider;

201.3. Notifies DCH of its election to make PE determinations;

201.4. Agrees to make PE determinations consistent with DCH's policies and procedures;

201.5. Assists individuals in completing and submitting the full single streamlined application and understanding any documentation requirements; and

201.6. Has not been disqualified by DCH.

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

202. Summary of Process

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

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

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

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

203. Certification Process and Liability

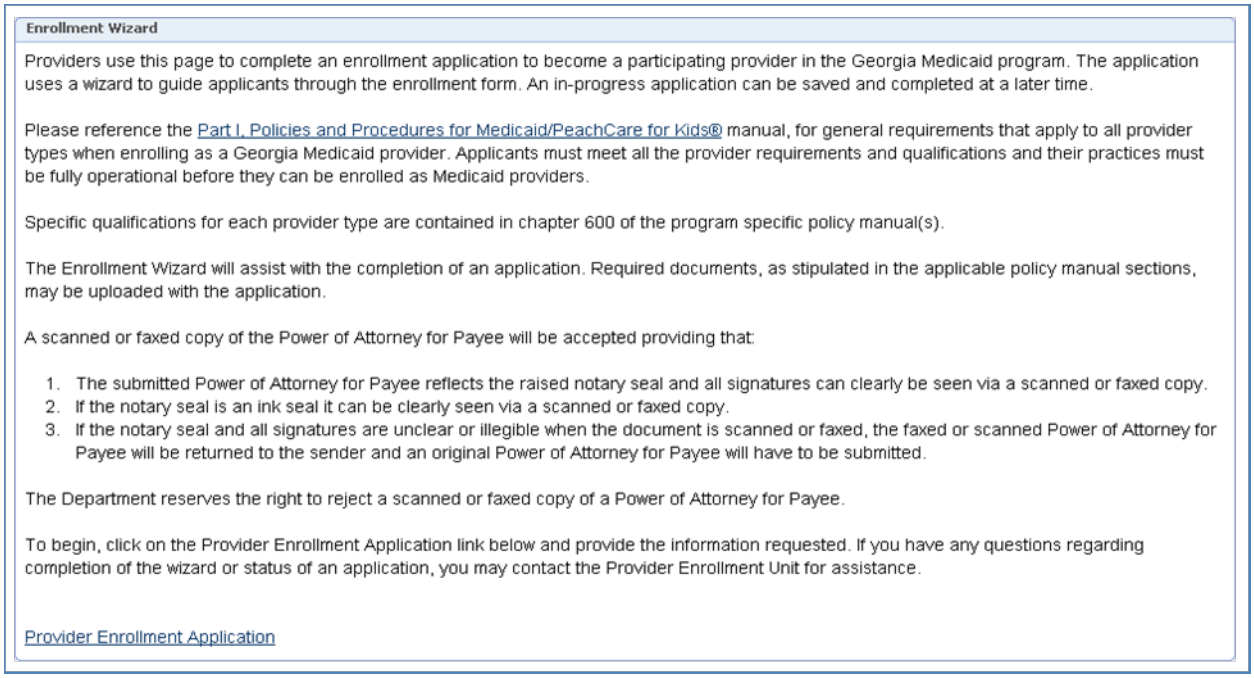
Per the Affordable Care Act (ACA), hospitals who meet the requirements of participation will be given the opportunity to become Qualified Hospitals by completing PE Medical Assistance training. The training requirement is met by attending a presumptive workshop and satisfactorily performing the training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

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

A hospital interested in becoming a QH should contact:

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

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



203.1. Disqualification of a Hospital

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

203.1.1. Making, or is not capable of making, PE determinations in accordance with applicable DCH policies and procedures; or

203.1.2. Meeting the DCH standard.

203.1.3. 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

204.1.1. Make correct determinations of PE Medical Assistance;

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

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

204.1.4. Inform the applicant in writing of the results of the PE Medical

Assistance determination;

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

205. Hospital Presumptive Eligibility (HPE) Training Schedule

Training will consist of two parts. The first part is a prerecorded training session. The second part isan assessment, and participants must score at least 80% on the PE Pregnant Women assessment and complete the Sign-In Sheet to be qualified to process PE Pregnant Women applications. A link to both the assessment and the Sign-In Sheet will be provided. Once both parts are completed, the PE Coordinator or Supervisor must submit a signed statement of completion, which should be signed by both the PE Coordinator or Supervisor and the employee. (Rev. 12/2025)

If you have any questions regarding the training, please contact Jacqueline Huggins at HPE.Inquiries@dch.ga.gov.

206. Services

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

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

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

Note: Dental coverage ends the day pregnancy is terminated.

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

Chapter 300: General Program Requirements

301. Right to Apply

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 hpe.inquiries@dch.ga.gov

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

If applicant is pregnant and active on SSI, QH should complete the SSI Pregnant Women Update form and send form securely to DCH at hpe.inquiries@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 hpe.inquiries@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 hpe.inquiries@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 Jacqueline.huggins3@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:

302.1. Are you a health plan or health care clearinghouse?

302.2. 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?

302.3. 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:

302.3.1. Disclosures to or requests by a health care provider for treatment purposes.

302.3.2. Disclosures to the individual who is the subject of the information.

302.3.3. Uses or disclosures made pursuant to an individual's authorization.

302.3.4. Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules.

302.3.5. Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes.

302.3.6. 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

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

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

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

306. Planning for Healthy Babies® (P4HB)

The Center for Medicare and Medicaid Services (CMS) approved a 10-year extension in August 2019 to the Planning for Healthy Babies® (P4HB) 1115 Demonstration Waiver. The P4HB demonstration covers Family Planning services to women ages 18 through 44 who are at or below 211 percent of the federal poverty level (FPL), who are U.S. Citizens and Georgia residents, who do not qualify for other Medicaid benefits and any other insurance coverage with the exception of vision or dental insurance, including Medicare or PeachCare for Kids®.

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

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

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

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

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

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

See the P4HB post cards located in Appendix R.
See the Family Planning policy manual located on the GAMMIS web portal.

Chapter 400: Application and Enrollment Process

401. Procedural Responsibilities of a Qualified Hospital

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.

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

401.1.1. 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;

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

401.1.3. determine if the applicant meets the PE Medical Assistance eligibility criteria;

401.1.4. 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.

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

401.2.1. 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

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

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

401.2.4. Assistance determination;

401.2.5. inform the applicant of the PE period;

401.2.6. 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;

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

401.2.8. provide the applicant with the P4HB information.

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

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

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

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

401.2.13. 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;

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

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

401.2.16. 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

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.

502. 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:

502.1. Is under the age of 19;

502.2. 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:

502.3. The individual's spouse;

502.4. The individual's natural, adopted and step children under the age of 19; and

502.5. 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:

502.6. 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

502.7. 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.

Note: 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).

503. Citizenship/Immigration Status

503.1. 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:

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

503.1.1.1. Lawful permanent residents

503.1.1.2. 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

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

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

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

503.1.2.2. 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

503.1.2.3. 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.

503.1.2.4. 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.

503.1.3. 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.

503.1.4. 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.

504. 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 hpe.inquiries@dch.ga.gov

Acceptable identity and/or citizenship documents:

504.1. No Identity Required on these Citizenship Verifications:

504.1.1. US Passport (not limited passports)

504.1.2. Certificate of Naturalization (N-550 or N-570)

504.1.3. Certificate of Citizenship (N-560 or N-561)

505. Identity Required with these Citizenship Verifications:

505.1. US Public Birth Record showing birth in one of the 50 states; District of Columbia; American Territories; or Guam

505.2. US birth certificate or data match with a State Vital Statistic Agency

505.3. Certification of Report of Birth (DS-1350)

505.4. Consular Report of Birth Abroad of a Citizen of the U.S.(FS-240)

505.5. Certification of Birth Abroad (FS-545)

505.6. United States Citizen Identification Card (I-197 or the prior version I-

505.7. 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.

505.8. Collective Naturalization document/Northern Mariana Identification Card (I-873)

505.9. Final Adoption Decree

505.10. Evidence of civil service employment by the US government

505.11. Official Military record

505.12. Federal or State census record showing US citizenship indicating a US place of birth

505.13. Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs

505.14. Statement signed by the physician or midwife who was in attendance at the time of birth

505.15. One of the following documents created at least 5 years before the application for Medical Assistance showing a US place of birth:

505.15.1. Extract of hospital record on hospital letterhead established at the time of person's birth

505.15.2. Life, health or other insurance record

505.15.3. An amended US public birth record

505.15.4. Medical clinic, doctor or hospital record indicating a US place of birth

505.15.5. Institutional admission papers from nursing home, skilled nursing care facility or other institution

506. Acceptable Verification of Identity:

506.1. State Driver's license bearing the individual's picture or Georgia Identification Card

506.2. Certificate of Indian Blood; US American/Alaska Native tribal document; or Native American Tribal Document

506.3. US Military Card or draft record; Military dependent's ID card with photograph; US Coast Guard Merchant Mariner Card

506.4. Identification card issued by federal, state or local government agencies or entities with photo or identifying information

506.5. School Identification card with a photograph

506.6. US passport issued with Limitations

506.7. 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

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:

604.1. Pre-tax deductions

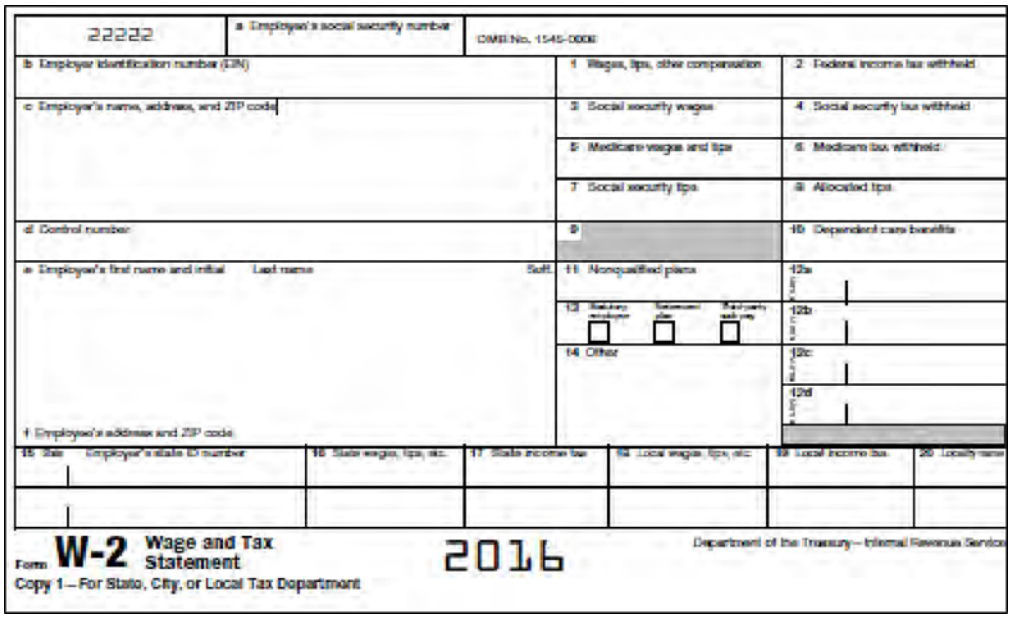
604.2. Form 1040 deductions

604.3. 5% FPL deduction (only use if needed to make individual(s) eligible)

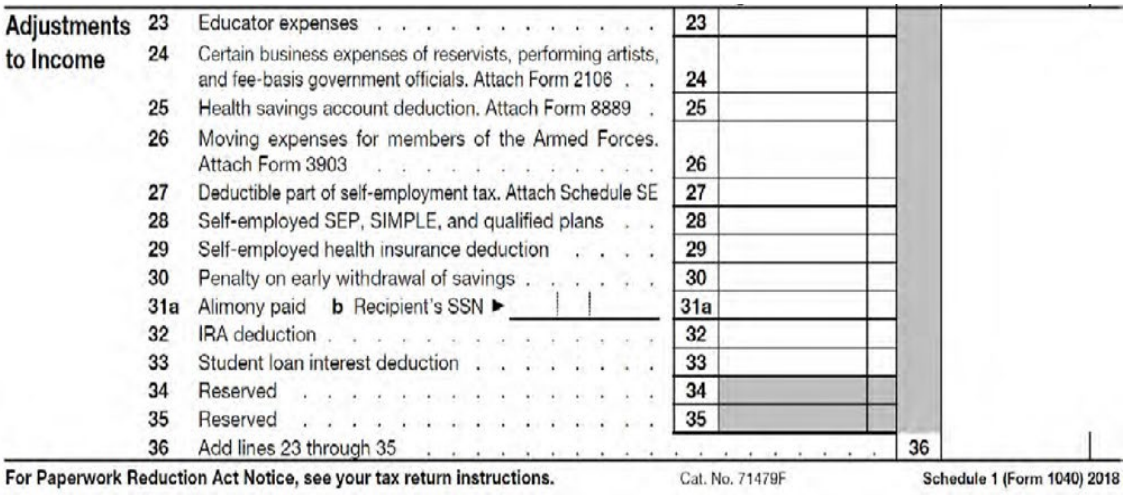
Note: MAGI-based income of the applicant's child, who is under the age of 19, is excluded, if they are not required to file a tax return.

605. 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.



1040 Deductions:
Are located on the IRS Tax Return form 1040:



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

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

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

606. 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.

Fluctuating Income

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

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.

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:

701.1. 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.

701.2. 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.

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

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

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

QH should complete the PE Manual Updates form and email along with the PE application (632H) to DCH at pecorrections@dch.ga.gov. Complete only the section(s) that need to be updated. DCH will complete updates the same business day if received by 5:00 pm. If received after 5:00 pm or on the weekend, updates will be completed the next business day.

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

portal.

702. 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:

702.1. 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.

702.2. 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.

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

703. 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

704. 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:

704.1. The applicant is not a U.S. Citizen, U.S. National, or qualified immigrant.

704.2. The applicant's net family taxable income is above the allowable percentage of the federal poverty level limit.

704.3. The applicant is not a Georgia resident.

704.4. The applicant is not the appropriate age for the PE Medical Assistance.

704.5. The applicant is not a Former Foster Care child

704.6. The applicant states she is not pregnant.

704.7. 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:

704.8. 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.

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

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

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

Appendix A
Questions & Answers

A. 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.

B. 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.

C. 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.

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

i. Not being a Georgia Resident

ii. Not being a U.S. Citizen, U.S. National or qualified immigrant

iii. Not being at or below the appropriate FPL income limit

iv. Not being the appropriate age

v. Not being a Former Foster Care child

vi. Not being pregnant per applicant's statement

vii. Unable to determine, applicant refuses to verbally give tax status information

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

i. Inform the applicant verbally and in writing that they have been approved.

ii. Explain what PE Medical Assistance is and what it covers.

iii. Give the applicant a temporary Medical Assistance certificate and explain how they should use it.

iv. Explain the Single Streamlined Medical Assistance application (94a) will be given to the DFCS team to make the ongoing/retroactive Medicaid determination.

v. 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.

vi. Provide the applicant with the P4HB information.

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

i. Inform the applicant they have been denied, and why.

ii. Explain to them that if their circumstances change, they may have another determination for PE

performed by the QH.

iii. Give them Notice of ADA/Section 504 Rights, HIPAA notice, form 634H - Notice of Action-Denial and/or GAMMIS Denial Notice.

iv. 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.

v. Provide the applicant with the P4HB information.

G. 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.

H. 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.

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

The QH should follow the procedures outlined in Chapter 700.

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

See step by step process in Appendix G.

K. 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.

L. 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.

M. How do I order forms?

Forms 632H (PE Application), 634H (Notice of Action – Approval/Denial), 5460 (HIPAA), DMA 285 (Third Party Liability), Quick Guide on PE Medical Assistance, SSI Pregnant Women and PE Manual Updates can be printed from the web portal.

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

N. 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://mok,l/oedicaid.georgia.gov/planning-healthy-babies

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

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

O. 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.

P. 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.

Q. 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").

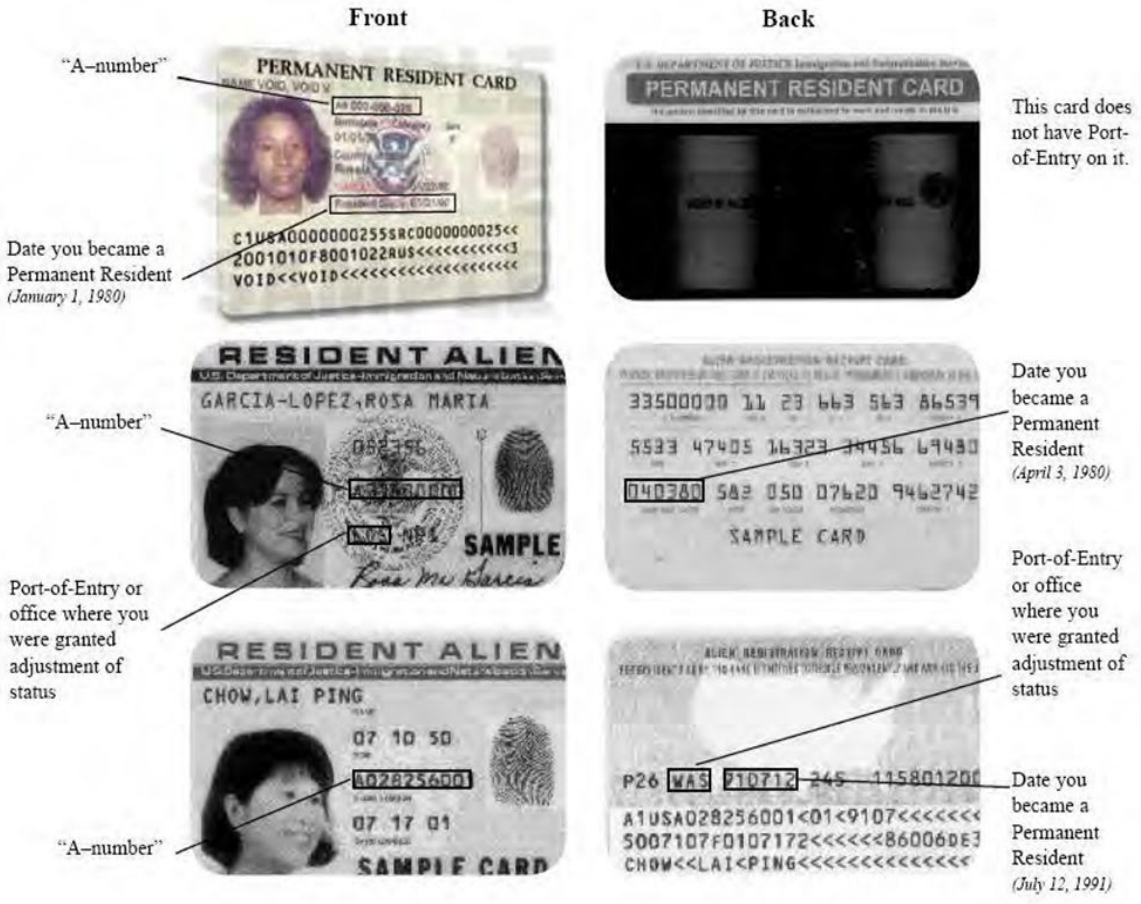
R. Sample Passport

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

renewal or green card replacement.



Previous Permanent Resident Cards



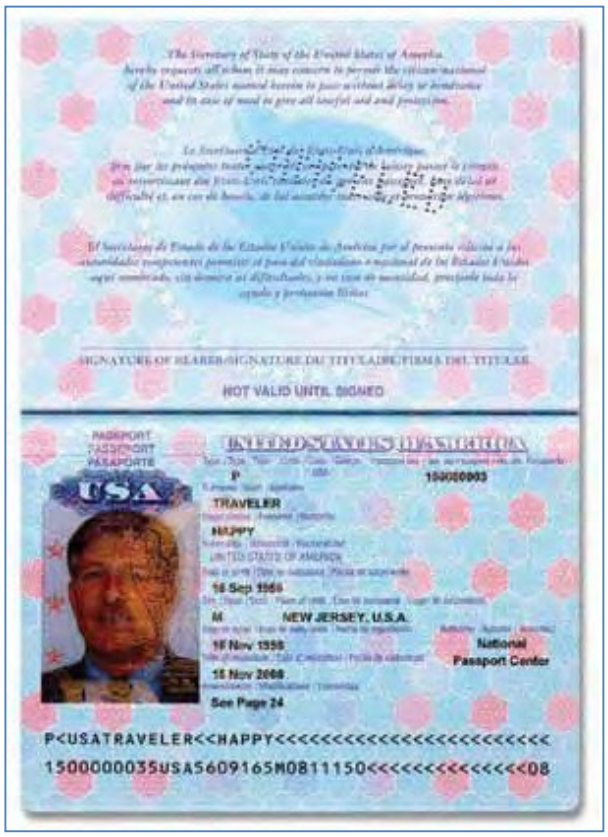
NOTE: The "A–number" is the Alien Registration Number

S. What is a passport?

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

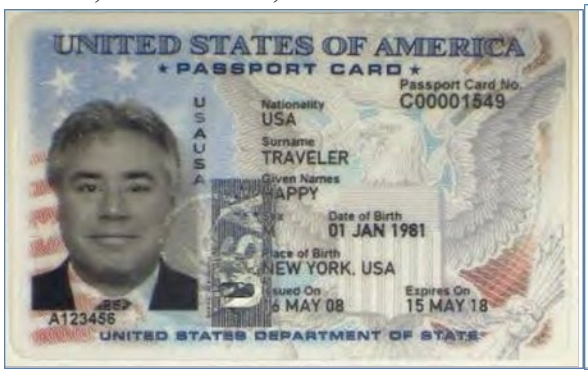
Current U.S. Passport **Older U.S. Passport**





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.

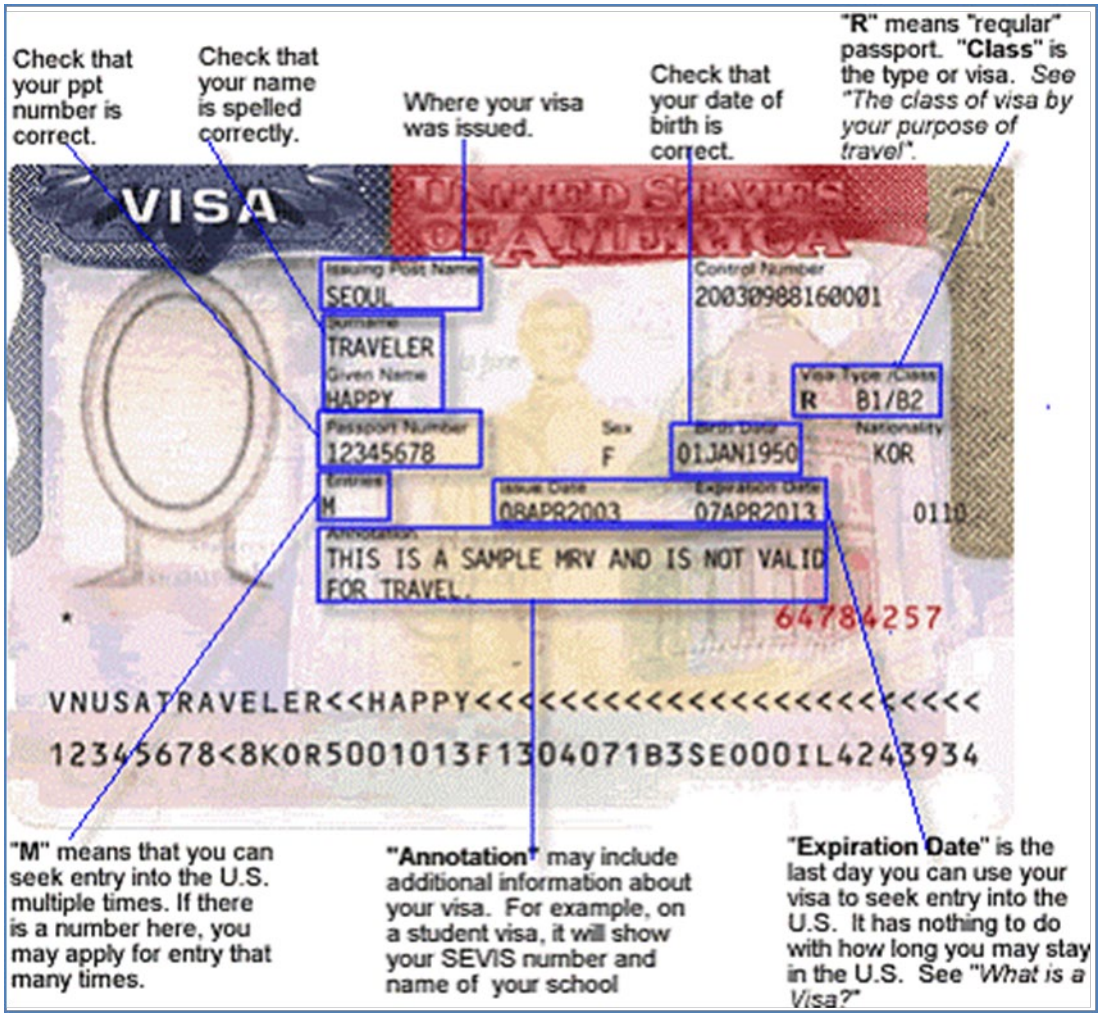




T. How do I read and understand a Visa?

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

as a temporary visitor).



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

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



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



U. 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.

V. 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.

i. 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.

ii. J Visa: Academic Studies as an Exchange Visitor

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

iii. 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.

W. Business Visa

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

X. 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.

Y. 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 B
Class of Assistance

A. 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

B. 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)

C. WAIVERS

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

259	CCSP – COMMUNITY CARE WAIVER

D. 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

E. 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

F. 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

G. 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

H. 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

I. 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

J. P4HB

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

K. CBAY

258	COMMUNITY BASED ALTERNATIVE FOR YOUTH

L. HOSPTIAL PRESUMPTIVE

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

M. 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

N. CONVERSION / DEFAULT

915	AGED MAO
916	BLIND MAO
917	DISABLED MAO
918	LIM ADULT
919	LIM CHILD
920	REFUGEE ADULT
921	REFUGEE CHILD
924	FOSTER CARE
931	CHILD WELFARE FOSTER CARE
983	AGED MEDICALLY NEEDY
984	BLIND MEDICALLY NEEDY
985	DISABLED MEDICALLY NEEDY
	INACTVE
	NEW – EFFECTIVE 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, 1-877-423-4746 or local office if open) except the following aid categories:

Q-track (660, 661) – Complete the PE process to make a determination and send PE packet to DFCS (indicate on fax or in email, applicant active on Q-track also)

Q-track (662, 664) – Only have applicant complete the 94a, send application to DFCS

SSI (All 300 codes) – Complete the SSI Pregnant Women Update form and email to pecorrections@dch.ga.gov
P4HB (180, 181) – Complete the PE process to make a determination, add PE to GAMMIS if eligible, send PE packet to DFCS, complete the PE Manual Update form and send this form along with 632H & Attachment A (if applicable) to pecorrections@dch.ga.gov

Women's Health (245) – Refer to DFCS or you send email to womenshealth@dhs.ga.gov

Inmate (815, 817) – Complete the PE process to make a determination (DO NOT add PE to GAMMIS if eligible), ask applicant for release date, send release date and 632H to DCH, send PE packet to DFCS (Note: DCH will verify release date, enter approved PE in GAMMIS and contact member)

Hospital Presumptive (801, 802, 806, 852) – Inform applicant already active

Presumptive/Other Medicaid (800, 835, 864, 876, 871, 870) - Inform applicant already active

Appendix C
Examples

A. Presumptive Eligibility Period

i. 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.

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

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

B. Budget Group Composition

i. 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

ii. 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 stepdaughter and the two mutual children. Mr. Long is applying for Medical Assistance for everyone. 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

iii. 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.

C. Income

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

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

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

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

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

i. 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.

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

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

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

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

Pregnant Women BG of 4 income limit - $5720

Pamela is PE eligible for Pregnant Women

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

Appendix D
List of Forms

A. List of Forms

Form Number	Page Number	Form Name	Revision Date
632H (pages 1 & 2)	F-6	PE Application	08/2021
94a	F-10	Single Streamlined Medical Assistance Application (94a)	09/2017
94a SP	F-22	Single Streamlined Medical Assistance Application (94a) (Spanish)	09/2017
634H	F-37	Notice of Action (Approval)	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

Appendix E
Instructions on Form

A. 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.

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

B. Completion of Individual Items:

Effective for Services Beginning:	Enter the date the application is completed and signed.
Medical Assistance Identification Number:	Lister the twelve (12) digit number that begins with 111 or 222.
Applicant's Name:	Enter name of applicant
Applicant's Maiden Name:	Enter maiden name of applicant if applicable.
Applicant's Address (City, State, Zip Code):	Enter mailing address where card is to be sent.
County of Residence:	Enter applicant's county of residence.
Telephone Number:	Enter applicant's contact phone number.
SS Number	This field is optional.
Health Insurance:	Ask applicant if anyone in the household has other health insurance and check the corresponding box.
Former Foster Care Child:	Ask applicant if anyone in the household has been in Foster Care and check the corresponding box. If there is a Former Foster Care Child, then ask, what age did they leave foster care and what state did they receive foster care from.
Tax Filer/Non-Tax Filer Household:	Ask applicant if h/she expects to file taxes or be claimed as a tax dependent. Use
	the budget group flow chart to determine if BG will be tax filer or non-tax filer household and check Yes next to corresponding box.
Budget Group Member(s):	Enter the applicant's name on the first line. Enter other budget group member(s)' name on the remaining lines.
Date of Birth:	Enter the birth dates of all budget group member(s).
Race, Gender, Relationship to applicant:	Enter information for all budget group member(s).
US Citizen, US National or Lawfully Present Immigrant? Y/N	Ask applicant about citizenship/immigration status for all budget group member(s) and enter Yes or No.

Monthly Gross Income:	Enter the type of income: **C** = Commissions **W** = Earned income (wages or salaries) **OU** = Other unearned income **P** = Pensions **SE** = Self-employment Enter the amount of the income. Enter the frequency of the income: **A** = Annually **B** = Biweekly **W** = Weekly **SM** = Semi-monthly **M** = Monthly Convert all income to a monthly amount.
Monthly Deductions:	Enter total monthly pre-tax deductions and/or monthly 1040 deductions.
Monthly Net Income:	Enter net income for each budget group member by subtracting allowable deductions from monthly gross taxable income.
Subtotal Net Income:	Enter the total monthly net income for the budget group.
Number in Budget Group:	Enter number of person(s) included in the budget group.
Poverty Income Level:	Enter the amount of the income limit for the budget group size and Medical Assistance COA.
5% FPL Deduction:	Enter the 5% FPL of the budget group, if needed to make any person(s) in the budget group eligible.
Total Net Income:	Enter the amount remaining after the 5% FPL amount is subtracted from the subtotal net income field. Compare this amount to the poverty income level.
Eligible/Ineligible:	After comparing the Total Net Income to Poverty Income Level, if income is less, check the Eligible box. If income is more, check the ineligible box.
PE Medical Assistance COA:	If eligible, check the corresponding box for the COA.

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

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

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

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

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.

Appendix E
Hospital Presumptive Application

EFFECTIVE FOR SERVICES BEGINNING _____
MONTH DAY YEAR

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

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

_____
MEDICAL ASSISTANCE IDENTIFICATION NUMBER

HOSPITAL PRESUMPTIVE ELIGIBILITY MEDICAL ASSISTANCE

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

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

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

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

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

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

SWORN STATEMENT OF APPLICANT:

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

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

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

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

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

_____ _____
DATE OF APPLICATION APPLICANT'S SIGNATURE

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

632H (8/30/21)

SUBTOTAL NET INCOME =
NUMBER IN BUDGET GROUP =
POVERTY INCOME LEVEL =

5 % FPL DEDUCTION =
TOTAL NET INCOME =

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

☐ PARENT/CARETAKER WITH CHILD(REN) ☐ PREGNANT WOMEN
☐ CHILD(REN) UNDER 19 ☐ FORMER FOSTER CARE (Up to age 26)

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

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

_____ _____
DIRECT PHONE NUMBER SIGNATURE OF QUALIFIED HOSPITAL PERSONNEL

_____ _____
QUALIFIED HOSPITAL NAME AND ADDRESS QH PROVIDER ID

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

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

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

HOSPITAL PRESUMPTIVE ELIGIBILITY MEDICAL ASSISTANCE

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

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

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

A. SPECIAL NOTE TO MEMBER:

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

B. 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.

C. 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.

D. 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.

E. 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.

F. 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 hpe.inquiries@dch.ga.gov. These documents are available in English and Spanish.

Appendix F
Single Streamline Medical Application (Form 94A and Attachments A, B and C) English

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Application for Health Coverage & Help Paying Costs

Form Approved
OMB No. 0938-1191

THINGS TO CONSIDER

Use this application to see what coverage 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 premium for health coverage.
- Free or low-cost insurance from **Medical Assistance**.
  You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Attachment C.
- Pathways Medical Assistance is a program that provides free or reduced cost Medicaid Coverage to individuals ages 19 to 64, who have household income up to 100% of the Federal Poverty Level (FPL), not otherwise eligible for Medicaid and who meet the eligibility requirements. If you would like to be considered for Pathways, you need to complete this application and Attachment D.

Apply faster online

Apply faster online at gateway.ga.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any eligible 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 information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to the address on page 8.
If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit gateway.ga.gov or call **1-877-423-4746**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** gateway.ga.gov
- **Phone:** Call our Help Center at **1-877-423-4746.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-423-4746** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-877-423-4746.**

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

Form 94a (Rev. 7/2023)

STEP 1 Tell us about yourself.

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

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)? _____

a. Do you need an interpreter? ☐ Yes ☐ No

*You have the option to choose how you would like to receive notifications about your information. If you choose to receive email or text notifications, you will receive a message notifying you that you have a notice in My Notices located in GA Gateway Customer Portal.
For Email Communication, you must provide us with your email address and accept the terms and conditions for paperless notices located in GA Gateway Customer Portal after you create an account. Please visit the GA Gateway Customer Portal Website at www.gateway.ga.gov to update your notification settings.
For Texting Communication, you must provide us with your phone number. Standard message and data rates may apply. This may vary by carriers, please check with your provider.

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 (including stepchildren)
- Your unmarried partner who needs health coverage if you have shared children and at least one child is applying for coverage
- Anyone you include on your tax return, even if they don't live with you

You DON'T have to include:

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

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

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

STEP 2: PERSON 1 (Start with yourself)

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

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

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

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

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

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

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No If yes, what is the estimated due date / / ; and how many babies are expected? _____
If no, did you deliver or was a pregnancy terminated within the last 12 months? ☐ Yes ☐ No
If yes, what was the delivery/termination date? / / ; and how many babies were delivered/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. Are you **naturalized** or **derived citizen**? *(This usually means you were born outside of the U.S.)* ☐ Yes ☐ No
If Yes, please provide your Alien number and Certificate number. Alien number _____ Certificate number _____

12. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your Immigration document type and Alien/Certificate number below.
a. Immigration document type _____ b. Alien/Certificate 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

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

14. 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

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

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

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL—check all that apply.)**

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

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

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28

CURRENT JOB 1:

19. Employer name and address

20. Employer phone number
( ) –

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

$ _____

22. Average hours worked each WEEK

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

23. Employer name and address

24. Employer phone number
( ) –

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

$ _____

26. Average hours worked each WEEK

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

28. **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?

$ _____

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

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

☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type: _____

Date Divorce/Separation was finalized or last modified: ___/___/____

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

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

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid $ How often? Date Divorce/Separation was finalized or last modified: ___/___/____

☐ Student loan interest $ How often?

☐ Health Insurance premiums, 401K, and Other Pre-Tax deductions $ Type: How often?

☐ Other deduction $ Type: How often

31. **YEARLY INCOME:** **Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to the next person.

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

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

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

STEP 2: PERSON 2

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

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

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

5. Social Security number (SSN) ---------- _____
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

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

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No If yes, what is the estimated due date / / ; and how many babies are expected? _____
If no, did PERSON 2 deliver or was a pregnancy terminated within the last 12 months? ☐ Yes ☐ No
If yes, what was the delivery/termination date for PERSON 2? / / ; and how many babies were delivered/expected? _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. Are you **naturalized** or **derived citizen**? *(This usually means you were born outside of the U.S.)* ☐ Yes ☐ No
If Yes, please provide your Alien number and Certificate number. Alien number _____ Certificate number _____

13. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their Immigration document type and Alien/Certificate number below.
a. Immigration Document type _____ b. Alien/Certificate number _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

14. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

15. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is under the age of 19.

17. Did PERSON 2 have health insurance and lose it within the past 2 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 2 a full-time student? ☐ Yes ☐ No

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

20. **Race (OPTIONAL—check all that apply.)**

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

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

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 21.

☐ **Not employed**
Skip to question 31.

☐ **Self-employed**
Skip to question 30.

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number
( ) –

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

$ _____

24. Average hours worked each WEEK

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

25. Employer name and address

26. Employer phone number
( ) –

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

$ _____

28. Average hours worked each WEEK

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

30. **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?

$ _____

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

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

☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type: _____

Date Divorce/Separation was finalized or last modified: _ /___/____

32. **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 30b).

☐ Alimony paid $ How often? Date Divorce/Separation was finalized or last modified: ___/___/____

☐ Student loan interest $ How often?

☐ Health Insurance premiums, 401K, and Other Pre-Tax deductions $ Type: How often?

☐ Other deduction $ Type: How often?

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

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

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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

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

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

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Attachment B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **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 (If you check this box, complete the next four rows below and Attachment A.)

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.**

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):
Please let us know if due to disability you require any reasonable modifications or communication assistance. Reasonable modifications allow an individual with a disability an equal opportunity to participate in all public assistance programs for which an individual may be otherwise eligible to receive.

Do you have a disability that will require a Reasonable Modification or Communication Assistance? Yes__ No ___
(If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):
Sign Language interpreter ___; TTY ____; Large Print ____; Electronic communication (email) _; Braille _____; Video Relay ___; Cued Speech Interpreter___ ; Oral Interpreter ___; Tactile Interpreter ___; Telephone call reminder of program deadlines ___; Telephonic signature (if applicable) ___; Face-to-face interview (home visit) ___; Other:_____
Do you need this Reasonable Modification or Communication Assistance one-time ___ or ongoing ___?
If possible, briefly explain when and how long you need this modification or assistance?

For more information and additional ways to request a reasonable modification or communication assistance please see the attached Notice of ADA/Section 504 on page 9.

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.

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit gateway.ga.gov or call **1-877-423-4746** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by calling the DFCS Civil Rights, ADA/Section 504 Coordinator at 1-877-423-4746.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated. *(An incarcerated individual may still be found eligible for Medicaid.)*
  (Name of person)

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agree that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law and/or regulations.

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.

Express Lane Eligibility:

Express Lane Eligibility (ELE) is an automatic process to enroll or renew eligible children under the age of 19 who are receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) into the Medical Assistance program.
If you are receiving SNAP or TANF, the Division of Family and Children Services (DFCS) will use the household size, residency, and income information from SNAP or TANF, but DFCS will verify citizenship or immigration status using Medical Assistance rules to make an ELE determination to enroll or renew the children in Medicaid or PeachCare for Kids®. If your children are eligible for PeachCare for Kids®, they may be subject to a premium. DFCS will send you a determination notice, let you make any changes and allow you to opt out at any time.

If you would like your children to be evaluated for Medical Assistance using the ELE process, please select yes or no below.
☐ Yes ☐ No

My right to appeal

If I think the Health Insurance Agencies, DFCS and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS or the FFM that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at **1-877-423-4746**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Attachment C.

Signature	Date (mm/dd/yyyy)

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

STEP 6 Mail completed application.

Mail your signed application to the address below:

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

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

_____ Yes
_____ No
_____ I do not want to answer the Voter Registration question

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at 2 Martin Luther King Jr. Drive, Ste. 802, West Tower, Atlanta, GA 30334 or by calling 404-656-2871.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.

To report suspected Medicaid fraud on recipients or providers, call the Georgia Department of Community Health-Office of Inspector General at (local) 404-463-7590 or (toll free) 800-533-0686; by email at oiganonymous@dch.ga.gov; by mail at Department of Community Health, OIG PI Section, 2 Martin Luther King Jr. Drive SE, 19th Floor, East Tower, Atlanta GA 30334; or visit https://dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

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 (877) 423-4746 or the DCH Katie Beckett (KB) Team 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 KB office, online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, or you may email your modification request to DCH.ADAassistance@dch.ga.gov.

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 47 Trinity Avenue SW, Atlanta, GA 30334, (877) 423-4746. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Suite 150, Norcross, GA 30071 or P.O. Box 172, Norcross, GA 30091, (678) 248-7449. The DCH email is: dch.adarequests@dch.ga.gov.

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. The email for DCH Civil Rights complaints is: dch.civilrights@dch.ga.gov. The link for the DCH Civil Rights process and complaint form is located at: https://dch.georgia.gov/adasection-504-and-civil-rights.

**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.*

Under the Department of Human Services (DHS), you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at Georgia Department of Human Services, Office of General Counsel, 47 Trinity Avenue SW, Atlanta, GA 30334, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at Georgia Department of Human Services, Office of General Counsel, 47 Trinity Avenue SW, Atlanta, GA 30334, (877) 423-4746.

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.

APPLICANT Information *List the person applying for Medical Assistance offered health coverage from a job*

1. Applicant name (First, Middle, Last)	2. Applicant Date of Birth (mm/dd/yyyy)	3. Applicant Social Security Number
	_____ /_____ /_____	_____ -_____- _____

EMPLOYEE Information *Skip this section if the person listed above is also the Employee*

4. Employee name (First, Middle, Last)	5. Employee Date of Birth (mm/dd/yyyy)	6. Employee Social Security Number
	_____ /_____ /_____	_____ -_____- _____

EMPLOYER Information

7. Employer name		8. Employer Identification Number (EIN) _____ - _____
9. Employer address		10. Employer phone number ( ) –
11. City	12. State	13. ZIP code
14. Who is the employer contact that can provide information about your employee health coverage? Name (First, Middle, Last)		
15. Phone number (if different from ( ) –	16. Email address	

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

☐ **Yes** (Continue)

17a. If yes, please enter the start date (mm/dd/yyyy): _____ /_____ /_____

17b. If yes, please indicate your relationship to the Employee with access to coverage: ☐ Self ☐ Spouse ☐ Dependent

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

Name:_____ Relation to Employee: · Spouse · Dependent

Name:_____ Relation to Employee: · Spouse · Dependent

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

Tell us about the **health plan** offered by this employer.

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

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

19a. How much would the employee have to pay in premiums for this plan? **$** _____

19b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐ Quarterly ☐Yearly

20. During the open enrollment period, what changes will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.*

20a. How much will the employee have to pay in premiums for that plan? **$** _____

20b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

20c. 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).**

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EMPLOYER COVERAGE TOOL

Georgia Department of Human Services — Division of Family and Children Services

Georgia Department of Community Health

Form Approved
OMB No. 0938-

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 18 on this page should match question 18 on Attachment A.

Write your name, date of birth, and Social Security number in boxes 1, 2, and 3 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. Employee Date of Birth (mm/dd/yyyy)	3. Employee Social Security Number
	_____ /_____ /_____	_____ -_____- _____

EMPLOYER Information

Ask the **employer** for this information.

7. Employer name		8. Employer Identification Number (EIN) _____ - _____
9. Employer address		10. Employer phone number ( ) –
11. City	12. State	13. ZIP code
14. Who is the employer contact that can provide information about your employee health coverage? Name (First, Middle, Last)		
14. Phone number (if different from above) ( ) –	16. Email address	

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

☐ **Yes** (Continue)

17a. 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 18)

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

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

19a. How much would the employee have to pay in premiums for this plan? **$** _____

19b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

20. During the open enrollment period, what changes will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.*

20a. How much will the employee have to pay in premiums for that plan? **$** _____

20b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

20c. Date of change (mm/dd/yyyy): _____

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

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

Form 94a Attachment A (7/2023)

ATTACHMENT B

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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

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

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

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

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

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

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

Form 94a Attachment B (7/2023)

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 or organization 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 or organization 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. If you need to assign more than one authorized representative, please complete another Attachment C.

1. Person Name (First name, Middle name, Last name)

2. Address | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code

7. Phone number
( ) –

8. Organization name | 9. ID number (if applicable)

10. Authorized Representative Duties: Sign application on applicant's behalf ❑ Complete and submit renewal form ❑
Receive copies of notices and other communication ❑ Act on behalf of applicant in all other matters ❑

11. Preferred Language | 12. Is an interpreter needed? Yes ❑ No ❑

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.

13. Your signature | 14. Date (mm/dd/yyyy)

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):
Please let us know if due to disability you require any reasonable modifications or communication assistance. Reasonable modifications allow an individual with a disability an equal opportunity to participate in all public assistance programs for which an individual may be otherwise eligible to receive.

Do you have a disability that will require a Reasonable Modification or Communication Assistance? Yes__ No___(If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):
Sign Language interpreter____; TTY____; Large Print____; Electronic communication (email)____; Braille_____; Video Relay____; Cued Speech Interpreter____; Oral Interpreter____; Tactile Interpreter___; Telephone call reminder of program deadlines__; Telephonic signature (if applicable)___; Face-to-face interview (home visit).; Other:_____
Do you need this Reasonable Modification or Communication Assistance one-time__or ongoing ___?
If possible, briefly explain when and how long you need this modification or assistance?

For more information and additional ways to request a reasonable modification or communication assistance please see the attached Notice of ADA/Section 504 on page 9 of the full Medical Assistance application.

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

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

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name | 4. ID number (if applicable)

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

Form 94a Attachment C (7/2023)

Appendix G
Single Streamline Medical Application (Form (94A and Attachments A, B, and C) Spanish



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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Solicitud de cobertura de salud y ayuda para pagar los costos

Formulario aprobado por la OMB Nro. 0938-1191

ASPECTOS A TENER EN CUENTA

Utilice esta solitud para ver para qué cobertura califica

- Planes de seguro médico privados y asequibles que ofrecen una cobertura integral para ayudarle a mantenerse saludable.
- Un crédito tributario nuevo que puede ayudarle a pagar sus primas de la cobertura de salud de inmediato.
- Seguro gratuito o de bajo costo de **Asistencia Médica.**
  Puede calificar para obtener un programa gratuito o de bajo costo incluso si gana hasta $94,000 al año (para una familia de 4).

¿Quiénes pueden utilizar esta solicitud?

- Utilice esta solicitud para aplicar para cualquier miembro de su familia.
- Realice la solicitud incluso si usted o su hijo/a ya tiene cobertura de salud. Puede ser elegible para recibir una cobertura de menor costo o gratuita.
- Si es soltero/a, puede utilizar un formulario más corto. Ingrese a HealthCare.gov.
- Las familias que incluyen inmigrantes pueden realizar la solicitud. Puede realizar la solicitud para su hijo/a incluso si usted no es elegible para la cobertura. Realizar la solicitud no afectará su estado de inmigración ni las posibilidades de convertirse en un residente o ciudadano permanente.
- Si alguien le está ayudando a completar este formulario, es posible que necesite completar el Anexo C.

Realice la solitud en línea más rápido

Realice la solicitud en línea más rápido en gateway.ga.gov.

Lo que puede necesitar para realizar la solicitud

- Los Números de Seguro Social (o los números de documento para cualquier persona inmigrante legal que necesite el seguro)
- La información del empleador y de los ingresos para todos los miembros de su familia (por ejemplo, de los recibos de pago, formularios W-2, o de las declaraciones de salario o de impuestos)
- Números de póliza de cualquier seguro médico actual
- Información sobre cualquier seguro médico relacionado al empleo que esté disponible para su familia

¿Por qué le solicitamos esta información?

Le solicitamos información sobre los ingresos y otra información para informarle para qué cobertura califica y si puede obtener ayuda para pagarla. **Mantendremos segura y privada** toda la información que proporciona**, según lo exige la ley.**

¿Qué sucede a continuación?

Envíe la solicitud completa y firmada a la dirección que figura en la página 8.
Si no tiene toda la información que solicitamos, firme y envíe la solicitud de todas maneras. Nos pondremos en contacto con usted dentro de 1 a 2 semanas. Obtendrá instrucciones para realizar los siguientes pasos para completar su cobertura de salud. Si no obtiene respuesta de nuestra parte, ingrese a gateway.ga.gov o llame al **1-877-423-4746**. Completar esta solicitud no quiere decir que tiene que comprar la cobertura de salud.

Obtenga ayuda con esta

- **En línea:** gateway.ga.gov
- **Teléfono:** Llame a nuestro Centro de Ayuda al **1-877-423-4746.**
- **En persona:** Es posible que haya asesores en su área que pueden ayudarle. Ingrese a nuestro sitio web o llame al **1-877-423-4746** para obtener más información.
- **En español:** Llame a nuestro centro de ayuda gratis al **1-877-423-4746.**

¿NECESITA AYUDA CON SU SOLICITUD? Ingrese a 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** e infórmele al representantede atención al cliente el idioma que necesita. Le brindaremos ayuda sin costo para usted. Los usuarios de TTY deben llamar al **1-800-255-0135**.

Formulario 94a (Rev. 10/2022)

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, y sufijo

2. Dirección del hogar (Deje en blanco si no tiene uno.)			3. Número de departamento o suite
4. Ciudad	5. Estado	6. Código postal	7. Condado
8. Dirección de correo postal (si es distinta de la dirección del hogar)			9. Número de departamento o suite
10. Ciudad	11. Estado	12. Código postal	13.Condado

14. Número de teléfono	15.Otro número de teléfono
( ) -	( ) -

16. ¿Desea recibir información sobre esta solicitud por correo electrónico? ■ Sí ■ No

Dirección de correo electrónico: _____

17. ¿Cuál es su idioma hablado o escrito de preferencia (si no es el inglés)?

a. Si se requiere una entrevista, ¿necesitará un/a intérprete? ■ Sí ■ No

***** Tiene la opción de elegir cómo le gustaría recibir notificaciones sobre su información. Si elige recibir notificaciones por correo electrónico o mensaje de texto, recibirá un mensaje que le notificará que tiene un aviso en Mis Avisos ubicado en el Portal del Cliente de GA Gateway.
Para la comunicación por correo electrónico, debe proporcionarnos su dirección de correo electrónico y aceptar los términos y condiciones de los avisos electrónicos que se encuentran en el Portal del Cliente de GA Gateway después de crear una cuenta. Visite el sitio web del Portal del Cliente de GA Gateway en www.gateway.ga.gov para actualizar la configuración de las notificaciones.
Para la comunicación por mensaje de texto, debe proporcionarnos su número de teléfono. Se pueden aplicar tarifas estándar de mensajes y datos. Esto puede variar según la compañía, consulte con su proveedor.

PASO 2 Cuéntenos sobre su familia.

¿A quiénes necesita incluir en esta solicitud?

Cuéntenos sobre todos los miembros de la familia que viven con usted. Si presenta impuestos, necesitamos la información de todas las personas en su declaración de impuestos. (No es necesario que presente impuestos para obtener la cobertura de salud).

INCLUYA a:

- Usted
- Su cónyuge
- Sus hijos/as menores de 21 años que viven con usted
- Su pareja sin casarse que necesita cobertura de salud
- Cualquier persona que incluya en su declaración de impuestos, incluso si no viven con usted
- Cualquier otra persona menor de 21 años que usted cuide y viva con usted.

NO es necesario que incluya a:

- Su pareja sin casarse que no necesita cobertura de salud
- Los hijos/as de su pareja sin casarse
- Sus padres que viven con usted, pero presentan sus propias declaraciones de impuestos (si usted es mayor de 21 años)
- Otros parientes adultos que presentan sus propias declaraciones de impuestos

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

Complete el Paso 2 para cada persona en su familia. Comience con usted, luego agregue otros adultos/as o niños/as. Si tiene más de 2 personas en su familia, necesitará realizar una copia de las páginas y adjuntarlas. No es necesario que proporcione el estado de inmigración o un Número de Seguro Social (SSN, en inglés) para los miembros de la familia que no necesitan la cobertura de salud. Mantendremos segura y privada toda la información que proporciona, según lo exige la ley. Utilizaremos la información personal solo para verificar si es elegible para obtener la cobertura de salud.

(Comience con usted)

Complete el Paso 2 para usted, su cónyuge/pareja y los niños/as que viven con usted o cualquier persona en su misma declaración de impuestos federales si presenta una. Consulte la página 1 para obtener más información sobre a quiénes incluir. Si no presenta una declaración de impuestos, recuerde agregar aun así a los miembros de la familia que viven con usted.

1. Primer nombre, segundo nombre, apellido, y sufijo

2. ¿Vínculo con usted? **USTED**

3. Fecha de nacimiento(mm/dd/aaaa)

4. Sexo ▪ Masculino ▪ Femenino

5. Número de seguro social(SSN) ---------- ___ ___ ___ ___

Lo necesitamos si desea obtener la cobertura de salud y tiene un SSN. Proporcionar su SSN también puede ser de ayuda su no desea obtener la cobertura de salud ya que puede acelerar el proceso de solicitud. Utilizamos los SSN para verificar los ingresos y otra información para ver quiénes son elegibles para recibir ayuda con los costos de la cobertura de salud. Si alguien desea recibir ayuda para obtener un SSN, llame al 1-800-772-1213 o ingrese a **socialsecurity.gov.** Los usuarios de TTY deben llamar al1-800-255-0135.

6. **¿Planea presentar una declaración de impuestos federales el PRÓXIMO AÑO?**
(Aún puede realizar una solicitud para obtener un seguro médico incluso si no presenta una declaración de impuestos federales.)

▪ **Sí Si la respuesta es sí,** responda las preguntas a–c. ▪ **NO. Si la respuesta es no,** diríjase a la pregunta c.

a. ¿Presentará de manera conjunta con un cónyuge? ▪ Sí ▪ No
Si la respuesta es sí, nombre del/de la cónyuge: _____

b. ¿Reclamará a alguien como dependiente en su declaración de impuestos? ▪ Sí ▪ No
Si la respuesta es sí, indique el(los) nombre(s) de el(los) dependientes**:** _____

c. ¿Usted será reclamado como dependiente en la declaración de impuestos de otra persona? ▪ Sí ▪ No
Si la respuesta es sí, indique el nombre de la persona que declara impuestos: _____
¿Cuál es su vínculo con la persona que declara impuestos?_____

¿Está embarazada? ▪ Sí ▪ Si la respuesta es sí, ¿cuál es la fecha de parto estimada / / ; y cuántos bebes se esperan?_____
Si la respuesta es no, ¿dio a luz o un embarazo se interrumpió en los últimos 12 meses? ❑ Sí ❑ No
Si la respuesta es sí, ¿cuál fue la fecha de parto o terminación del embarazo? / / ; y cuántos bebés nacieron/se esperaban?
_____

7. **¿Necesita una cobertura de salud?**
(Incluso si tiene seguro, puede existir un programa con una mejor cobertura o con costos más bajos.)

▪ **YES. Si la respuesta es sí,** responda todas las preguntas a continuación.

▪ **NO. Si la respuesta es no,** DIRÍJASE a las preguntas sobre los ingresos en la página 3. Deje el resto de esta página en blanco.

8. ¿Tiene una condición de salud física, mental, o emocional que genere limitaciones en las actividades (como bañarse, vestirse, las tareas diarias, etc.) o vive en una institución médica u hogar de cuidados? ▪ Sí ▪ No

9. ¿Es un/a cuidadano/a de los EE.UU. o nacional de EE.UU.? ▪ Sí ▪ No

10. **Si no es un ciudadano/a de EE.UU. ni nacional de EE.UU.,** ¿tiene un estado de inmigración elegible?
▪ Sí Complete con el tipo de documento de inmigración y el número de certificado/extranjero a continuación.
a. Tipo de documento de _____
b. Número de certificado/extranjero _____
c. ¿Ha vivido en EE.UU. desde 1996? ▪ Sí ▪ No
d. ¿Usted, su cónyuge o su padre es un veterano o un miembro en servicio activo de las fuerzas armadas de los EE.UU.? ▪ Sí ▪ No

11. ¿Desea obtener ayuda para pagar las facturas médicas de los últimos 3 meses? ▪ Sí ▪ No

12. ¿Vive con al menos un niño/a menor de 19 años, y usted es la persona principal que cuida de este/a niño/a? ▪ Sí ▪ No

13. ¿Es usted un/a estudiante de tiempo completo? ▪ Sí ▪ No

14. ¿Estuvo en un hogar de acogida a los 18 años o más? ▪ Sí ▪ No

15. **Si es hispano/latino, origen étnico (OPCIONAL: marque todo lo que corresponda.)**
▪ Mexicano ▪ Mexicano-estadounidense ▪ Chicano ▪ Puertorriqueño ▪ Cubano ▪ Otro_____

16. **Raza (OPCIONAL: marque todo lo que corresponda.)**

▪ Blanca	▪ Indio-americana o nativa de Alaska	▪ Filipina	▪ Vietnamita	▪ Guameña o Chamorra
▪ Negra o afroamericana	▪ Indo-asiática	▪ japonesa	▪ Otra Asiática	▪ Samoana
	▪ china	▪ coreana	▪ Nativa Hawaiana	▪ Otra Isleña del Pacífico
				▪ Otra _____

¿NECESITA AYUDACONSU SOLICITUD? Ingrese a **gateway.ga.gov** o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. Si necesitaayuda en otro idiomaque no sea el inglés, llame al **1-877-423-4746** e infórmele al representante de atenciónal cliente el idiomaque necesita. Le brindaremosayuda sin costo para usted. Los usuarios de TTY deben llamar al **1-800-255-0135**.

PASO 2: PERSONA 1 (Continúe con su información propia)

Empleo actual e información de ingresos

- ▪ **Con empleo** Si está empleado/a actualmente, infórmenos sobre sus ingresos. Comience con la pregunta 18.
- ▪ **Sin empleo** Diríjase a la pregunta 28.
- ▪ **Empleo por cuenta propia** Diríjase a la pregunta 27.

EMPLEO ACTUAL 1:

18.Nombre y dirección del empleador

19.Número de teléfono del empleador ( ) -

20.Salarios/propinas (antes de los impuestos) ▪ Por hora ▪ Por semana ▪ Cada 2 semanas ▪ Dos veces al mes ▪ Mensual ▪ Anual

$_____

21.Promedio de horas trabajadas cada SEMANA

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

22.Nombre y dirección del empleador

23.Número de teléfono del empleador ( ) -

24.Salarios/propinas (antes de los impuestos) ▪ Por hora ▪ Por semana ▪ Cada 2 semanas ▪ Dos veces al mes ▪ Mensual ▪ Anual

$_____

25.Promedio de horas trabajadas cada SEMANA

26.**En el último año:** ▪ cambió de trabajo ▪ dejó de trabajar ▪ comenzó a trabajar menos horas ▪ comenzó a trabajar más horas ▪ ninguna de las anteriores

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

a. Tipo de trabajo

b. ¿Cuánto ingreso neto (ganancias una vez pagados los gastos comerciales) obtendrá de este empleo por cuenta propia este mes?
$ _____

28.**OTROS INGRESOS:** Marque todo lo que corresponda, e indique el monto y cada cuánto lo obtiene.
AVISO: No es necesario que nos informe sobre la manutención infantil, el pago de veteranos, ni la Seguridad de Ingreso Suplementario (SSI).

- ▪ Ninguno
- ▪ Pensiones por desempleo $ ¿Con qué frecuencia?
- ▪ Seguro Social $ ¿Con qué frecuencia?
- ▪ Cuentas de jubilación $ ¿Con qué frecuencia?
- ▪ Pensión recibida $ ¿Con qué frecuencia?
- ▪ Agricultura/pesca neta $ ¿Con qué frecuencia?
- ▪ Renta neta/regalías $ ¿Con qué frecuencia?
- ▪ Otros ingresos $ ¿Con qué frecuencia?
  Tipo: _____

29.**DEDUCCIONES:** Marque todo lo que corresponda, e indique el monto y cada cuánto lo paga.
Si paga por ciertas cosas que se pueden deducir en una declaración de impuestos federales sobre los ingresos, informarnos sobre ellas puede hacer que el costo de la cobertura de salud sea un poco más bajo.
AVISO: No debe incluir un gasto que ya consideró en su respuesta al empleo por cuenta propia neto (pregunta 27b).

- ▪ Pensión pagada $ ¿Con qué frecuencia?
- ▪ Interés del préstamo estudiantil
- ▪ Primas de seguro médico, 401K y otras deducciones antes de impuestos $ Tipo: ¿Con qué frecuencia?
- ▪ Otras deducciones $ Tipo: ¿Con qué frecuencia?

30.**INGRESO ANUAL: Complételo únicamente si su ingreso cambia de mes a mes.**
Si no espera cambios en su ingreso mensual, diríjase a la siguiente persona.

Su ingreso total **este año**	Su ingreso total **el año** próximo (si piensa que será distinto)
$	$

¡GRACIAS! Esto es todo lo que necesitamos saber sobre usted.

¿NECESITA AYUDACONSU SOLICITUD? Ingrese a gateway.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. Si necesitaayuda en otro idiomaque no sea el inglés, llame al **1-877-423-4746** e infórmele al representante de atenciónal cliente el idiomaque necesita. Le brindaremosayuda sin costo para usted. Los usuarios de TTY deben llamar al **1-800-255-0135**.

PASO 2: PERSONA 2

Complete el Paso 2 para usted, su cónyuge/pareja y los niños/as que viven con usted o cualquier persona en su misma declaración de impuestos federales si presenta una. Consulte la página 1 para obtener más información sobre a quiénes incluir. Si no presenta una declaración de impuestos, recuerde agregar aun así a los miembros de la familia que viven con usted.

1. Primer nombre, segundo nombre, apellido, y sufijo

2. ¿Vínculo con usted?

3. Fecha de nacimiento(mm/dd/aaaa)

4. Sexo ▪ Masculino ▪ Femenino

5. Número de seguro social(SSN)---------- ___ ___ ___ ___
Lo necesitamos si desea obtener una cobertura de salud y tiene un SSN.

6. ¿La PERSONA 2 vive en la misma dirección que usted? ▪ Sí ▪ No
Si la respuesta es no, indique la dirección:_____

7. **¿La PERSONA 2 planea presentar una declaración de impuestos federales el PRÓXIMO AÑO?**
(Aún puede realizar una solicitud para obtener un seguro médico incluso si no presenta una declaración de impuestos federales.)
▪ **SÍ. Si la respuesta es sí,** responda las preguntas a–c. ▪ **NO. Si la respuesta es no,** diríjase a la pregunta c.
   a. ¿La PERSONA 2 presentará de manera conjunta con un cónyuge? ▪ Sí ▪ No
   Si la respuesta es sí, nombre del/de la cónyuge:_____
   b. ¿La PERSONA 2 reclamará a alguna persona como dependiente en su declaración de impuestos? ▪ Sí ▪ No
   Si la respuesta es sí, indique el(los) nombre(s) de el(los) dependientes:_____
   c. ¿La PERSONA 2 será reclamada como dependiente en la declaración de impuestos de otra persona? ▪ Sí ▪ No
   Si la respuesta es sí, indique el nombre de la persona que **presenta** impuestos: _____
   ¿Qué relación tiene la PERSONA **2** con la persona que presenta impuestos?_____

8. ¿La PERSONA 2 está embarazada? ▪ Sí ▪ No Si la respuesta es sí, cuál es la fecha de parto estimada / / ; y cuántos bebés se esperan? _____
Si la respuesta es no, ¿la PERSONA 2 dio a luz o un embarazo se interrumpió en los últimos 12 meses? ▪ Sí ▪ No
Si la respuesta es sí, ¿cuál fue la fecha de parto o terminación del embarazo de la PERSONA 2? / / ; y cuántos bebés nacieron/se esperaban? _____

9. **¿La PERSONA 2 necesita una cobertura de salud?**
(Incluso si tiene seguro, puede existir un programa con una mejor cobertura o con costos más bajos.)
▪ **Sí. Si la respuesta es sí,** responda todas las preguntas a continuación.
▪ **NO. Si la respuesta es no,** DIRÍJASE a las preguntas sobre los ingresos en la página 5. Deje el resto de esta página en blanco.

10. ¿La PERSONA 2 tiene una condición de salud física, mental, o emocional que genere limitaciones en las actividades (como bañarse, vestirse, las tareas diarias, etc.) o vive en una institución médica u hogar de cuidados? ▪ Sí ▪ No

11. ¿La PERSONA 2 es un/a cuidadano/a de los EE.UU. o nacional de EE.UU.? ▪ Sí ▪ No

12. **Si la PERSONA 2 no es un/a ciudadano/a de EE.UU. ni nacional de EE.UU.,** ¿tiene un estado de inmigración elegible?
▪ Sí. Complete con el tipo de documento de inmigración y el número de certificado/extranjero de la persona a continuación.
   a. Tipo de documento de inmigración _____
   b. Número de certificado/extranjero _____
   c. ¿La PERSONA 2 ha vivido en EE.UU. desde 1996? ▪ Sí ▪ No
   d. ¿La PERSONA 2, o su cónyuge o padre es un veterano o un miembro en servicio activo de las fuerzas armadas de EE.UU.? ▪ Sí ▪ No

13. ¿La PERSONA 2 desea obtener ayuda para pagar las facturas médicas de los últimos 3 meses? ▪ Sí ▪ No

14. ¿La PERSONA2 vive con al menos un/a niño/a menor de19 años, y es la persona principal que cuida de este niño/a? ▪ Sí ▪ No

15. ¿La PERSONA 2 estuvo en un hogar de acogida a los 18 años o más? ▪ Sí ▪ No

Responda las siguientes preguntas si la PERSONA 2 es menor de 19 años.

16. ¿La PERSONA 2 tenía seguro médico y lo perdió en los últimos 2 meses? ▪ Sí ▪ No
   a. Si la respuesta es **sí, fecha de finalización:**_____ b. Motivo por el cual **finalizó el seguro:**_____

17. ¿La PERSONA 2 es un/a estudiante de tiempo completo?▪ Sí ▪ No

18. **Si es hispano/latino, origen étnico (OPCIONAL: marque todo lo que corresponda.)**
▪ Mexicano ▪ Mexicano estadounidense ▪ Chicano ▪ Puertorriqueño ▪ Cubano ▪ Otro_____

19. **Raza (OPCIONAL: marque todo lo que corresponda.)**
▪ Blanca ▪ Negra o afroamericana ▪ Indio-americana o nativa de Alaska ▪ Indo-asiática ▪ china ▪ Filipina ▪ japonesa ▪ coreana ▪ Vietnamita ▪ Otra Asiática ▪ Nativa Hawaiana ▪ Guameña o Chamorra ▪ Samoana ▪ Otra Isleña del Pacífico ▪ Otra _____

Ahora, infórmenos sobre cualquier ingreso de la PERSONA 2 en el reverso.

¿NECESITA AYUDACONSU SOLICITUD? Ingrese a gateway.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. Si necesitaayuda en otro idiomaque no sea el inglés, llame al **1-877-423-4746** e infórmele al representante de atenciónal cliente el idiomaque necesita. Le brindaremosayuda sin costo para usted. Los usuarios de TTY deben llamar al **1-800-255-0135**.

PASO 2: PERSONA 2

Empleo actual e información de ingresos

- ▪ **Con empleo**
  Si está empleado/a actualmente, infórmenos sobre sus ingresos. Comience con la pregunta 20.
- ▪ **Sin empleo**
  Diríjase a la pregunta 30.
- ▪ **Empleo por cuenta propia**
  Diríjase a la pregunta 29.

EMPLEO ACTUAL 1:

20.Nombre y dirección del empleador

21.Número de teléfono del empleador
( ) -

22.Salarios/propinas (antes de los impuestos) ▪ Por hora ▪ Por semana ▪ Cada 2 semanas ▪ Dos veces al mes ▪ Mensual ▪ Anual

$_____

23.Promedio de horas trabajadas cada SEMANA

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

24.Nombre y dirección del empleador

25.Número de teléfono del empleador
( ) -

26.Salarios/propinas (antes de los impuestos) ▪ Por hora ▪ Por semana ▪ Cada 2 semanas ▪ Dos veces al mes ▪ Mensual ▪ Anual

$_____

27.Promedio de horas trabajadas cada SEMANA

28.**En el último año:** ▪ cambió de trabajo ▪ dejó de trabajar ▪ comenzó a trabajar menos horas ▪ comenzó a trabajar más horas ▪ ninguna de las anteriores

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

c. Tipo de trabajo

d. ¿Cuánto ingreso neto (ganancias una vez pagados los gastos comerciales) obtendrá de este empleo por cuenta propia este mes?
$ _____

30.**OTROS INGRESOS:** Marque todo lo que corresponda, e indique el monto y cada cuánto lo obtiene.
AVISO: No es necesario que nos informe sobre la manutención infantil, el pago de veteranos, ni la Seguridad de Ingreso Suplementario (SSI).

- ▪ Ninguno
- ▪ Pensiones por $ ¿Con qué frecuencia?
- ▪ desempleo $ ¿Con qué frecuencia?
- ▪ Seguro Social $ ¿Con qué frecuencia?
- ▪ Cuentas de jubilación $ ¿Con qué frecuencia?
- ▪ Pensión recibida $ ¿Con qué frecuencia?
- ▪ Agricultura/pesca neta $ ¿Con qué frecuencia?
- ▪ Renta neta/regalías $ ¿Con qué frecuencia?
- ▪ Otros ingresos $ ¿Con qué frecuencia?
  Tipo: _____

31.**DEDUCCIONES:** Marque todo lo que corresponda, e indique el monto y cada cuánto lo paga.
Si paga por ciertas cosas que se pueden deducir en una declaración de impuestos federales sobre los ingresos, informarnos sobre ellas puede hacer que el costo de la cobertura de salud sea un poco más bajo.
AVISO: No debe incluir un gasto que ya consideró en su respuesta al empleo por cuenta propia neto (pregunta 27b).

- ▪ Pensión pagada $ ¿Con qué frecuencia?
- ▪ Interés del préstamo estudiantil
- ▪ Primas de seguro médico, 401K y otras deducciones antes de impuestos $ Tipo: ¿Con qué frecuencia?
- ▪ Otra deducción $ Tipo: ¿Con qué frecuencia?

32.**INGRESO ANUAL: Complételo únicamente si su ingreso cambia de mes a mes.**
Si no espera cambios en su ingreso mensual, diríjase a la siguiente persona.

Su ingreso total **este año**	Su ingreso total **el año** próximo (si piensa que será distinto)
$	**$**

¡GRACIAS! Esto es todo lo que necesitamos saber sobre la PERSONA 2.

Si tiene a más de dos personas para incluir, realice una copia del paso 2: Persona 2 (páginas 4 y 5) y complétalas.

¿NECESITA AYUDACONSU SOLICITUD? Ingrese a gateway.ga.gov o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. Si necesitaayuda en otro idiomaque no sea el inglés, llame al **1-877-423-4746** e infórmele al representante de atenciónal cliente el idiomaque necesita. Le brindaremosayuda sin costo para usted. Los usuarios de TTY deben llamar al **1-800-255-0135**.

PASO 3 Miembros familiares indio-americanos o nativos de Alaska (AI/AN)

1. **¿Usted o alguien en su familia es indio-americano o nativo de Alaska?**

- Si la respuesta es **no**, diríjase al paso 4.
- **Sí.** Si la respuesta es **sí,** diríjase al Anexo B.

PASO 4 La cobertura de salud de su familia

Responda estas preguntas para cualquier persona que necesite una cobertura de salud.

1. **¿Alguien está inscrito en una de las siguientes coberturas de salud en la actualidad?**

▪ **SÍ. Si la respuesta es sí,** marque el tipo de cobertura y escriba el(los) nombre(s) de la(s) persona(s) al lado de la cobertura que tienen. ▪ **NO.**

- ▪ Asistencia Médica _____
- ▪ Medicare_____
- ▪ TRICARE (No marque nada si tiene atención directa o Line of Duty)
- ▪ VA Programas de atención médica_____
- ▪ Cuerpos de Paz _____

- ▪ Seguro del empleador:_____
- ▪ Nombre del seguro médico: _____
  Número de póliza: _____
  ¿Es una cobertura COBRA? ▪Sí ▪No
  ¿Es un plan de salud de jubilado/a? ▪Sí ▪No
- ▪ Otro
  Nombre del seguro médico: _____
  Número de póliza:_____
  ¿Es un plan de beneficios limitados (como una póliza de accidente escolar)?
  ▪ Sí ▪ No

2. **¿A alguien indicado en esta solicitud se le ofrece una cobertura de salud de un empleo?** Marque sí incluso si la cobertura es del trabajo de otra persona, como de un padre o cónyuge.

- ▪ **SÍ. Si la respuesta es sí,** deberá completar e incluir el Anexo A.
- ▪ **NO. Si la respuesta es no, continúe al Paso 5.**

Ley de Estadounidenses con Discapacidades: Solicitud de modificaciones razonables y asistencia para la comunicación (si corresponde):

¿Tiene una discapacidad que requerirá una modificación razonable o asistencia para la comunicación? Sí__ No ____
(Si la respuesta es sí, describa la modificación razonable o la asistencia para la comunicación que solicita):
Intérprete de la lengua de señas___; TTY ____; Letra grande ___; Comunicación electrónica (correo electrónico)___; Braille ____; Retransmisión en video ___ ; Intérprete de habla con clave___ ; Intérprete oral ___; Intérprete táctil ___; Recordatorio por llamada telefónica de las fechas límite del programa ___; Firma telefónica (si corresponde) ___; Entrevista presencial (visita al hogar) ___; Otra:_____

¿Necesita esta modificación razonable o asistencia para la comunicación una sola vez ____ o permanentemente ___?
Si es posible, explique brevemente cuándo y por cuánto tiempo necesita esta modificación o asistencia.

Declaración informativa de la PRA
De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una recopilación de información a menos que muestre un número de control de la Oficina de Control y Presupuesto (OMB, en inglés) válido. El número de control de la OMB para esta recopilación de información es 0938-1191. El tiempo requerido para completar esta recopilación de información se estima en un promedio de [Insertar tiempo (horas o minutos)] por respuesta, incluido el tiempo para revisar las instrucciones, buscar recursos de datos existentes, recopilar los datos necesarios, y completar y revisar la recopilación de información. Si tiene comentarios respecto a la precisión de el tiempo estimado o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PASO 5 Lea y firme esta solicitud.

- Firmo esta solicitud bajo pena de perjurio, lo que significa que proporcioné respuestas verdaderas a todas las preguntas en este formulario a mi leal saber y entender. Estoy al tanto de que puedo estar sujeto/a a sanciones conforme a la ley federal si proporciono información falsa e incierta.
- Estoy al tanto de que debo informar cualquier cambio dentro de los 10 días calendario a partir de la fecha en la que sucedió el cambio. Puedo ingresar a gateway.ga.gov o llamar al **1-877-423-4746** para informar cualquier cambio. Entiendo que un cambio en mi información podría afectar la elegibilidad para miembro(s) de mi unidad familiar.
- Estoy al tanto de que, conforme a la ley federal, no se permite la discriminación por motivos de raza, color, nacionalidad, sexo, edad, orientación sexual, identidad de género o discapacidad. Puedo presentar un reclamo de discriminación al llamar al Coordinador de Derechos Civiles del DFCS, ADA/Sección 504 al 877-423-4746.
- Confirmo que ninguna persona que realiza una solicitud para el seguro médico en esta solicitud está presa (detenida o recluida). Si no, _____ **está preso/a.**
  (nombre de la persona)

El Departamento de Servicios Humanos de Georgia ("DHS") recopila información de identificación personal (PII, en inglés), como nombres, direcciones, números de teléfono, direcciones de correo electrónico y fechas de nacimiento, etc., durante su solicitud de beneficios. Al enviarnos cualquier información personal, usted acepta que podemos recopilar, usar y divulgar dicha información personal de acuerdo con las políticas y procedimientos del DHS, y según lo permitan o exijan las leyes o los reglamentos.

Necesitamos esta información para verificar su elegibilidad para obtener la ayuda para pagar la cobertura de salud si usted elige solicitarla. Verificaremos sus respuestas al utilizar la información en nuestras bases de datos electrónicas y en las bases de datos del Servicio de Impuestos Internos (IRS), el Seguro Social, el Departamento de Trabajo (DOL), el TALX (número de trabajo), el Departamento de Seguridad Nacional y una agencia de información sobre consumidores. Si la información no coincide, es posible que le solicitemos que nos envíe pruebas.

Renovación de la cobertura en los próximos años
Para que sea más fácil determinar mi elegibilidad para recibir ayuda para pagar la cobertura médica en los próximos años, acepto permitir que las agencias de seguros médicos, el DFCS y el Mercado Facilitado por el Gobierno Federal (FFM, en inglés) utilicen datos de los ingresos, incluida la información de las declaraciones de impuestos. Las agencias de seguro médico, el DFCS y el FFM me enviarán un aviso, me permitirán realizar cualquier cambio, y puedo optar por no participar en cualquier momento.
Sí, renovar mi elegibilidad automáticamente para los próximos

- 5 años (la cantidad máxima de años permitidos), o para una menor cantidad de años:
- 4 años ▪ 3 años ▪ 2 años ▪ 1 años ▪ No utilizar la información de mis declaraciones de impuestos para renovar mi cobertura.

Si alguien en esta solicitud es elegible para la Asistencia Médica

- Doy a la agencia de Asistencia Médica nuestros derechos para buscar y obtener cualquier dinero de otro seguro médico, acuerdos legales, u otros terceros. También doy a la agencia de Asistencia Médica los derechos para buscar y obtener asistencia médica para un cónyuge o padre/madre.
- ¿Algún niño/a en esta solicitud tiene un/a padre/madre que vive fuera del hogar? ▪ Sí ▪ No
- Si la respuesta es sí, estoy al tanto de que me solicitarán la cooperación con la agencia que cobra la asistencia médica de un/a padre/madre ausente. Si considero que cooperar para el cobro de la asistencia médica me hará daño a mí o a mi hijo/a, puedo informarle a Medicaid y es posible que no tenga que cooperar.

Elegibilidad Rápida:

"La Elegibilidad Rápida (ELE, por sus siglas en inglés) es un proceso automático para inscribir o renovar la inscripción al programa de Asistencia Médica para niños y niñas menores de 19 años que reciben el Programa de Asistencia de Nutrición Suplementaria (SNAP, por sus siglas en inglés) o el Programa de Asistencia Temporal para Familias Necesitadas (TANF, por sus siglas en inglés) en el programa de Asistencia Médica.
Si usted recibe SNAP o TANF, la División de Servicios para Familias y Niños (DSFC, por sus siglas en inglés) utilizará la información de estos programas, como el tamaño de la unidad familiar, la residencia y los ingresos de SNAP o TANF, pero la DFCS verificará la ciudadanía o el estado migratorio mediante el uso de las normas de la Asistencia Médica para realizar una determinación de ELE. De esta forma se inscribirá al/a niño/a o se renovará su inscripción a Medicaid o PeachCare for Kids®. Si su hijo/a es elegible para recibir PeachCare for Kids®, puede estar sujeto/a a una prima. La DFCS le enviará un aviso con la determinación, le dejará realizar cambios y le permitirá dejar de participar en cualquier momento.

Si desea que sus hijos/as sean evaluados para recibir la Asistencia Médica mediante el proceso de ELE, seleccione sí o no a continuación.
▪Sí ▪No

Mi derecho a apelar
Si considero que las agencias de seguro médico, el DFCS y el FFM han cometido un error, puedo apelar su decisión. Apelar significa informarle a alguien en las agencias de seguro médico, el DFCS o el FFM que considero que la acción es incorrecta, y solicitar una revisión imparcial de la acción. Estoy al tanto de que puedo informarme sobre cómo apelar al comunicarme con la División de Servicios para Familias y Niños (DFCS) al **1-877-423- 4746**. Estoy al tanto de que puedo ser representado/a en el proceso por alguien que no sea yo. Se me explicará mi elegibilidad y otra información importante.

¿NECESITA AYUDACONSU SOLICITUD? Ingrese a **gateway.ga.gov** o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. Si necesitaayuda en otro idiomaque no sea el inglés, llame al **1-877-423-4746** e infórmele al representante de atenciónal cliente el idiomaque necesita. Le brindaremosayuda sin costo para usted. Los usuarios de TTY deben llamar al **1-800-255-0135**.

Firme esta solicitud. La persona que completó el Paso 1 debe firmar esta solicitud. Si es un/a representante autorizado/a puede firmar aquí, siempre que haya proporcionado la información requerida en el Anexo C.

Firma	Fecha

Ley de Estadounidenses con Discapacidades: Solicitud de modificaciones razonables y asistencia para la comunicación para los/as representantes autorizados/as (si corresponde):

¿El/la representante autorizado/a tiene una discapacidad que requerirá una modificación razonable o asistencia para la comunicación? Sí__ No ___ (Si la respuesta es sí, describa la modificación razonable o la asistencia para la comunicación que solicita):
Intérprete de la lengua de señas___; TTY ____; Letra grande ___; Comunicación electrónica (correo electrónico)____; Braille ____; Retransmisión en video ___ ; Intérprete de habla con clave___ ; Intérprete oral ___; Intérprete táctil ___; Recordatorio por llamada telefónica de las fechas límite del programa ___; Firma telefónica (si corresponde) ___; Entrevista presencial (visita al hogar) ___; Otra:_____
¿El/la representante autorizado/a necesitará esta modificación razonable o asistencia para la comunicación una sola vez ___ o permanentemente___? Si es posible, explique brevemente cuándo y por cuánto tiempo necesita esta modificación o asistencia.

PASO 6 Envíe por correo la solicitud completa.

Envíe por correo la solicitud firmada a la dirección que figura a continuación:

División de Servicios para Familias y Niños
entro de Atención al Cliente
P.O. Box 4190
Albany, GA 31706

INFORMACIÓN DE REGISTRO DE VOTANTE

Si no está registrado/a para votar donde vive actualmente, ¿le gustaría realizar una solicitud para registrarse para votar aquí en la actualidad?

_____ Sí
_____ No
_____ No deseo responder la pregunta sobre el registro de votantes

Realizar una solicitud para registrarse o no registrarse para votar no afectará el monto de asistencia que le brindará esta agencia.

Si desea obtener ayuda para completar el formulario de solicitud de registro de votante, le ayudaremos. La decisión de buscar o aceptar ayuda es suya. Puede completar el formulario de solicitud en privado.

Si cree que alguien ha interferido con su derecho a registrarse o no registrarse para votar, su derecho a la privacidad al decidir si registrarse o solicitar registrarse para votar, o su derecho a elegir su propio partido político u otra preferencia política, puede presentar un reclamo ante el Secretario de Estado en 2 Martin Luther King Jr. Drive, Ste. 802, West Tower, Atlanta, GA 30334 o al llamar al 404-656-2871.

SI NO MARCA NINGUNA CASILLA, SE CONSIDERARÁ QUE HA DECIDIDO NO REGISTRARSE PARA VOTAR EN ESTE MOMENTO.

Se incluye una copia de la solicitud de registro de votantes de Georgia con las solicitudes de DFCS, las renovaciones y los formularios de cambio de dirección. También puede solicitar una solicitud de registro de votantes a su administrador/a del caso. Si completa una solicitud de registro de votantes, preséntela en la Oficina del Secretario de Estado de Georgia siguiendo las instrucciones proporcionadas en la solicitud de registro de votantes.

Para denunciar sospechas de fraude de Medicaid en beneficiarios o proveedores, llame al Departamento de Salud Comunitaria de Georgia, Oficina del Inspector General al 404-463-7590 (local) o al 800-533-0686 (línea gratuita); por correo electrónico a oiganonymous@dch.ga.gov; por correo al Departamento de Salud Comunitaria, Sección OIG PI, 2 Peachtree Street NW, 5th Floor, Atlanta, GA 30303; o ingrese a https://dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

Aviso de derechos de la ADA / Sección 504

Ayuda para personas con discapacidades

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 discapacidades la misma oportunidad de participar y calificar para los programas, servicios o actividades de los Departamentos. Esto incluye programas como SNAP, TANF y Asistencia Médica.

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

Cómo solicitar una modificación razonable o asistencia de comunicación

Comuníquese con su administrador/a del caso si tiene una discapacidad y necesita una modificación razonable, asistencia en la comunicación o ayuda adicional. Por ejemplo, llame si necesita ayuda o servicio para una comunicación eficaz, como un intérprete de lenguaje de señas. Puede comunicarse con el/la administrador/a del caso o llamar al DFCS al 877-423-4746, o al equipo de Katie Beckett (KB) del DCH al 678-248-7449 para realizar su solicitud. También puede realizar su solicitud utilizando el Formulario de solicitud de modificación razonable ADA de DFCS, que está disponible en su oficina local de DFCS o en línea en https://dfcs.georgia.gov/adasection-504-and-civil-rights, o puede obtener el Formulario de solicitud de modificación razonable de ADA del DCH por parte del equipo de KB o en línea en https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, pero no es necesario que utilice un formulario.

Cómo presentar un reclamo

Tiene derecho a presentar un reclamo si los Departamentos lo han discriminado debido a su discapacidad. Por ejemplo, puede presentar un reclamo por discriminación si ha solicitado una modificación razonable o un intérprete de lenguaje de señas que ha sido denegado o no se ha actuado dentro de un tiempo razonable. Puede presentar un reclamo oralmente o por escrito comunicándose con su administrador/a del caso, su oficina local de DFCS o el Coordinador de Derechos Civiles de DFCS, ADA / Sección 504 en 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, 1-877-423-4746. Para el DCH, comuníquese con el Coordinador del equipo KB, ADA/ Sección 504 en 2211 Beaver Ruin Road Suite 150, Norcross, GA, 30071, o el apartado postal 172, Norcross, GA 30091, 678-248-7449. El correo electrónico del DCH es el siguiente: dch.adarequests@dch.ga.gov.

Puede pedirle a su administrador/a del caso una copia del formulario de reclamo de derechos civiles de la DFCS, ADA/Sección 504. El formulario de reclamo también está disponible en https://dfcs.georgia.gov/adasection-504-and-civil-rights. Si necesita ayuda para presentar un reclamo por discriminación, puede comunicarse con el personal de la DFCS mencionado anteriormente. Las personas sordas o con problemas de audición o que puedan tener discapacidades del habla pueden llamar al 711 para que un operador se comunique con nosotros. El correo electrónico para los reclamos de derechos civiles del DCH es el siguiente: dch.civilrights@dch.ga.gov. El enlace para acceder al proceso de derechos civiles y al formulario de reclamos del DCH se encuentra en https://dch.georgia.gov/adasection-504-and-civil-rights.

** La Sección 504 de la Ley de Rehabilitación de 1973; la Ley de Estadounidenses con Discapacidades de 1990; y la Ley de Enmiendas a la Ley de Estadounidenses con Discapacidades de 2008 garantizan que las personas con discapacidades estén exentas de discriminación ilegal.*

Conforme al DHS, puede presentar un reclamo por discriminación al contactar a su oficina local de la División de Servicios para Familias y Niños (DFCS, por sus siglas en inglés) o al/a la coordinador/a de los derechos civiles de la DFCS, ADA/Sección 504 en 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, 1-877-423-4746. Para presentar reclamos por una supuesta discriminación por motivos de conocimientos limitados del inglés, contáctese con el Programa de Conocimiento Limitado del Inglés y Discapacidad Sensorial del DHS en 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, 1-877-423-4746 (voz).

ANEXO A

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Cobertura de salud de los trabajos

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

Cuéntenos sobre el **trabajo** que ofrece la cobertura.

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

Información sobre el EMPLEADO

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

Información sobre el EMPLEADOR

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

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

☐ **Sí** (Continúe)

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

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

Nombre: _____ Nombre: _____ Nombre: _____

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

Cuéntenos sobre el **plan de salud** ofrecido por este empleador.

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

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

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

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

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

☐ El empleador no ofrecerá cobertura de salud

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

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

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

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

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

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

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

HERRAMIENTA DE COBERTURA DEL EMPLEADOR

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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

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

Información sobre el EMPLEADO

El **empleado** tiene que llenar esta sección.

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

Información sobre el EMPLEADOR

Pídale al **empleador** esta información.

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

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

☐ **Sí** (Continúe)

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

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

Cuéntenos sobre el **plan de salud** ofrecido por este **empleador**.

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

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

☐ No

(Vaya a la pregunta 14)

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

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

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

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

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

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

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

☐ El empleador no ofrecerá cobertura de salud

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

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

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

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

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

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

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

ANEXO B

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

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

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

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

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

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

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

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

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

ANEXO C

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Formulario aprobado OMB No. 0938-1191

Asistencia para completar este formulario

Puede elegir un representante autorizado.

Puede dar permiso a una persona u organización de confianza para que hable con nosotros sobre esta solicitud, vea su información y actúe en su nombre en asuntos relacionados con esta solicitud, incluida la entrega de información sobre su solicitud y la firma de su solicitud en su nombre. Esta persona u organización se denomina "representante autorizado". Si alguna vez necesita cambiar su representante autorizado, comuníquese con la División de Servicios para Familias y Niños (DFCS, en inglés) al 1-877-423-4746. Si es un representante designado legalmente para alguien en esta solicitud, presente prueba con la solicitud. Si necesita asignar más de un representante autorizado, complete otro Anexo C.

1. Nombre de la persona (Primer nombre, segundo nombre, apellido)

2. Dirección		3. Número de suite o departamento
4. Ciudad	5. Estado	6. Código postal

7. Número de teléfono
( ) –

8. Nombre de la organización

9. Número de ID (si corresponde)

10. Poderes del representante autorizado: Firmar la solicitud en nombre del solicitante ☐ Completar y presentar un formulario de renovación ☐ Recibir copias de avisos y otras comunicaciones ☐ Actuar en nombre del solicitante en todos los demás asuntos ☐

11. Idioma preferido

12. ¿Se necesita un intérprete? Sí ☐ No ☐

Al firmar, autoriza a que esta persona firme su solicitud, obtenga información oficial sobre esta solicitud, y actúe en su nombre en todos los asuntos futuros con esta agencia.

13. Su firma

14. Fecha (mm/dd/aaaa)

Solo para asesores, coordinadores, agentes e intermediarios de solicitudes certificados.

Complete esta sección si es un asesor, coordinador, agente o intermediario de solicitudes certificado que está completando esta solicitud en nombre de alguien más.

1. Fecha de inicio de la solicitud (mm/dd/aaaa)

2. Primer nombre, Segundo nombre, Apellido & Sufijo

3. Nombre de la organización

4. Número de ID (si corresponde)

¿NECESITA AYUDA CON SU SOLICITUD? Visite **gateway.ga.gov** o llámenos al **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. Si necesita ayuda en otro idioma que no sea el inglés, llame al **1-877-423-4746** e infórmele al representante de atención al cliente el idioma que necesita. Le brindaremos ayuda sin costo para usted. Los usuarios de TTY deben llamar al **1-800-255-0135**.

Anexo C del Formulario 94a (4/2022)

Appendix H
Notice of Action PE Approval (Form 634 English/Spanish)



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor — Russel Carlson, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

NOTICE OF ACTION

Presumptive Eligibility Medical Assistance

_____
Date

Name _____

Address _____

City _____ State GA Zip Code _____

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

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

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

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

_____ _____
Signature of Qualified Hospital — Qualified Hospital Address

_____ _____ _____
Title — Phone Number — Qualified Hospital ID Number

634H Approval (Revised 9/14/23)

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

Equal Opportunity Employer

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Gobernador B

Russel Carlson, Comisionado

2 Martin Luther King Jr. Drive SE, Torre Este | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

AVISO DE ACCIÓN

Asistencia Médica de Elegibilidad Presuntiva

_____
Fecha

Nombre _____

DIRECCIÓN _____

Ciudad _____ Estado GA Código postal _____

☐ ELEGIBILIDAD PRESUNTIVA APROBADA: _____

Número de identificación de asistencia médica

Su solicitud de Asistencia Médica de Elegibilidad Presuntiva (PE) ha sido aprobada.

Cuando solicitó Asistencia Médica PE, es posible que también haya solicitado
Asistencia Médica continua/retroactiva. Su solicitud completa de Asistencia Médica será...
Envíe su solicitud a la Oficina de la División de Servicios para Familias y Niños (DFCS) para una determinación final de elegibilidad. La DFCS tomará una decisión sobre su solicitud completa de Asistencia Médica y le notificará por correo.

Su cobertura de Asistencia Médica PE finaliza cuando se realiza una determinación final de elegibilidad por la oficina de DFCS, o a más tardar el último día del mes siguiente al de su solicitud de PE.

_____
Firma del Hospital Calificado

_____
Dirección de Hospital Calificado

_____
Título

Número de teléfono

Número de identificación de hospital calificado

Aprobación 634H (revisada el 14/9/23)

Appendix I
Notice of Action PE Denial (Form634 English/Spanish)



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor — Russel Carlson, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

NOTICE OF ACTION

Presumptive Eligibility Medical Assistance

_____
Date

Name _____

Address _____

City _____ State GA Zip Code _____

☐ **PRESUMPTIVE ELIGIBILITY DENIED**

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

The reason for denial is: Choose Item

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

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

_____ _____
Signature of Qualified Hospital — Qualified Hospital Address

_____ _____ _____
Title — Phone Number — Qualified Hospital ID Number

634H Denial (Revised 9/14/23)

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

Equal Opportunity Employer

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Gobernador B

Russel Carlson, Comisionado

2 Martin Luther King Jr. Drive SE, Torre Este | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

AVISO DE ACCIÓN

Asistencia Médica de Elegibilidad Presuntiva

Fecha _____

Nombre _____

DIRECCIÓN _____

Ciudad _____ Estado GA Código postal _____

☐ ELEGIBILIDAD PRESUNTIVA DENEGADA

Su solicitud de Asistencia Médica de Elegibilidad Presuntiva (PE) ha sido denegada.

El motivo de la negación es: Elija un artículo.

Al solicitar Asistencia Médica PE, es posible que también haya solicitado Asistencia Médica continua o retroactiva. Su solicitud de Asistencia Médica se enviará a la Oficina de la División de Servicios para Familias y Niños (DFCS) para la determinación final de su elegibilidad. La DFCS podría determinar que usted podría ser elegible para otro tipo de Asistencia Médica y se lo notificará. Si no es elegible para Asistencia Médica, su solicitud se remitirá al Mercado Facilitado por el Gobierno Federal (FFM) para su consideración. El FFM le notificará directamente.

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

Firma del Hospital Calificado _____ Dirección de Hospital Calificado

Título _____ Número de teléfono _____ Número de identificación de hospital calificado

Denegación 634H (revisada el 14/9/23)

A. Instructions for Notice of Action

i. 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 hpe.inquiries@dch.ga.gov.

ii. 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 hpe.inquiries@dch.ga.gov.

iii. Completion Of Individual Items

iv. Complete the top part of the form showing identifying information:

v. 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:

vi. Net taxable income exceeds the income standard Not the correct age for the Medicaid

vii. Not a US Citizen, US National or Qualified Immigrant Not a GA resident

viii. Not a Former Foster Care child

ix. Not pregnant per the applicant's statement

x. Unable to determine, applicant refuses to verbally give tax status information.

xi. Enter whichever reason is correct.

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

xiii. The QH should complete the bottom part and sign the form

Appendix J
Notice Of Privacy Practices (English/Spanish)

Notice of Privacy Practices
Georgia Department of Human Services

Date*: *December 01, 2023

THIS NOTICE DESCRIBES HOW HEALTH (MEDICAL) AND 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 all 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 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 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. 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. 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 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 (PHI) and PII.

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. 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. 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
47 Trinity Avenue SW,
Atlanta, GA 30334
HIPAADHS@dhs.ga.gov
(404) 463-0590

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.

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

La PII facilitada al DHS por los clientes se utiliza deliberadamente para determinar la elegibilidad, aprobar, denegar o renovar los beneficios de asistencia pública. Los datos se mantienen con el fin de renovar los beneficios mediante la verificación de la elegibilidad, la denegación de la agencia de apoyo y la aprobación de las decisiones de renovación. Los datos se comparten para conseguir el objetivo de los programas. No crearemos, recopilaremos, utilizaremos ni divulgaremos PII para fines no autorizados por la ley.

CÓMO PUEDE EL DHS UTILIZAR Y DIVULGAR INFORMACIÓN MÉDICA:

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

Como exige la ley. El DHS divulgará información médica cuando así lo exija la legislación federal, estatal o local.

Para el tratamiento. El DHS puede utilizar y divulgar información médica para su tratamiento y para prestarle servicios médicos relacionados con su tratamiento. Por ejemplo, el DHS puede revelar información médica a doctores, personal de enfermería, técnicos u otro personal que esté 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 facilitar información sobre su plan de salud para que se pueda pagar el tratamiento.

Personas implicadas en su asistencia o en el pago de la misma. Cuando corresponda, el DHS podrá compartir información médica con una persona que participe en su atención médica o en el pago de la misma, como su familia o una amistad cercana. El DHS también podrá divulgar dicha información a una entidad que preste asistencia en caso de catástrofe.

Investigación. En determinadas circunstancias, el DHS puede utilizar y divulgar información médica con fines de investigación. Antes de que el DHS utilice o divulgue información médica para investigación, el proyecto se someterá a un proceso de aprobación especial. Incluso sin una aprobación especial, el DHS puede permitir a los investigadores consultar los historiales para ayudarles a identificar a los pacientes que pueden incluirse en su proyecto de investigación o para otros fines similares, siempre que no retiren ni se lleven copia de ninguna información médica.

Socios comerciales. El DHS puede divulgar información médica a nuestros socios comerciales que realizan funciones en nuestro nombre o nos proporcionan servicios si la información es necesaria para tales funciones o servicios. Por ejemplo, el DHS puede utilizar los servicios de una entidad independiente para prestar servicios de tecnología de la información. Todos los socios comerciales del DHS están obligados a proteger la privacidad de su información y no se les permite utilizar o divulgar ninguna información que no sea la especificada en nuestro contrato.

Reclusos o individuos bajo custodia. Si usted está preso en una institución correccional o bajo la custodia de un funcionario encargado de hacer cumplir la ley, el DHS puede divulgar información médica a la institución correccional o al funcionario encargado de hacer cumplir la ley. Esta divulgación sería necesaria: (1) para que la institución le preste atención médica; (2) para proteger su salud y seguridad o la salud y seguridad de otras personas; o (3) la seguridad de la institución penitenciaria.

USOS Y DIVULGACIONES QUE REQUIEREN QUE EL DHS LE OFREZCA LA OPORTUNIDAD DE OPONERSE Y ANULAR:

Personas implicadas en su asistencia o en el pago de la misma. A menos que usted se oponga, el DHS puede revelar a un miembro de su familia, un pariente, un amigo íntimo o cualquier otra persona que usted identifique, su información médica que esté directamente relacionada con la participación de esa persona en su atención médica. Si usted no puede expresar que está de acuerdo u oponerse a dicha divulgación, el DHS puede divulgar dicha información según sea necesario si se determina que es en su mejor interés 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 sólo se harán 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 necesaria su autorización por escrito antes de compartir su historial médico por cualquier otro motivo no autorizado por la ley. Si usted proporciona al DHS una autorización por escrito, puede revocarla en cualquier momento enviando una revocación por escrito al responsable de protección de datos a la dirección de contacto que figura más abajo. Una vez recibida, el DHS dejará de divulgar la información médica en virtud de la autorización. Sin embargo, la revocación no afectará a las divulgaciones realizadas en virtud de su autorización antes de que la revocara.

SUS DERECHOS:

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

Derecho de inspección y copia. Tiene derecho a inspeccionar y copiar la información médica que pueda utilizarse para tomar decisiones sobre su atención o el pago de la misma. Esto incluye los historiales médicos y de facturación, salvo las notas de psicoterapia. Para inspeccionar y copiar esta información médica, debe solicitarlo por escrito. 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 la copia, el envío por correo u otros suministros relacionados con su solicitud. El DHS no puede cobrarle honorarios si necesita la información para solicitar beneficios en virtud de la Ley del Seguro Social o de cualquier otro programa estatal o federal de beneficios basados en las necesidades. El DHS puede denegar su solicitud en determinadas y limitadas circunstancias. 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 directamente en la denegación de su solicitud, y el DHS acatará el resultado de la revisión.

Derecho a una copia electrónica de los historiales médicos electrónicos. Si su información médica se conserva en formato electrónico (lo que se conoce como historial médico electrónico o historia clínica electrónica), tiene derecho a solicitar que se le entregue o transmita a otra persona o entidad una copia electrónica de su historial. El DHS hará todo lo posible para proporcionar acceso a su información médica en la forma o el formato que usted solicite si es fácilmente producible en dicha forma o dicho formato. Si la información médica no puede obtenerse fácilmente en la forma o el formato que usted solicita, se le facilitará su historial en nuestro formato electrónico estándar. Si no desea esa forma o ese formato, se le facilitará una copia impresa legible. El DHS puede cobrarle una tarifa razonable por los costos de la mano de obra asociada a la transmisión del historial médico electrónico.

Derecho a recibir aviso de una infracción. Usted tiene derecho a que se le notifique en caso de infracción con respecto a su información de salud protegida (PHI, en inglés) y PII que no estén protegidas.

Derecho de modificación. 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 sea

conservada por o para nuestra oficina. Para realizar cambios, puede ir a través de su portal de usuario, ponerse en contacto con el servicio de atención al cliente del programa al que se está inscribiendo, ponerse en contacto con su gestor de casos o realizar su solicitud, por escrito, al responsable de protección de datos mencionado más abajo. Le recomendamos que revise periódicamente sus datos para asegurarse de que sean correctos.

Derecho a un informe sobre las divulgaciones. Usted tiene el derecho de solicitar una lista de ciertas divulgaciones que el DHS hizo de su información médica para propósitos diferentes al tratamiento, pago y operaciones de cuidado de salud o para las cuales usted proporcionó autorización por escrito. Para solicitar una explicación de las divulgaciones, debe dirigirse por escrito al responsable de protección de datos.

Derecho a solicitar restricciones. Usted tiene derecho a solicitar una restricción o limitación de la información médica que el DHS utiliza o divulga para tratamientos, pagos u operaciones de atención médica. Usted también tiene derecho a solicitar un límite en la información médica que el DHS divulgue a alguien involucrado 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 hacerlo por escrito. El DHS no está obligado a acceder a 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 funcionamiento de la atención médica y dicha información que 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, accederemos a su solicitud a menos que la información sea necesaria para proporcionarle tratamiento de urgencia.

Derecho a solicitar comunicaciones confidenciales. Tiene derecho a solicitar que el DHS se comunique con usted en relación con asuntos médicos de una determinada manera o en un determinado lugar. Por ejemplo, puede pedir que el DHS solo se ponga en contacto con usted por correo o en el trabajo. Para solicitar comunicaciones confidenciales, debe hacerlo por escrito. Su solicitud debe especificar cómo o dónde desea que nos pongamos en contacto con usted. El DHS atenderá las solicitudes razonables.

Derecho a una copia impresa de este aviso. Tiene derecho a recibir una copia impresa 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. Para obtener una copia impresa de este aviso, póngase en contacto con el responsable de protección de datos. También puede obtener una copia en el sitio web del DHS, en la página de inicio de la Oficina de Asuntos Legales:

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 PHI están protegidas con medidas de seguridad operativas, administrativas, técnicas y físicas razonables para garantizar su confidencialidad, integridad y disponibilidad y para evitar el acceso, uso o divulgación no autorizados de la información protegida. No vendemos la información que se nos facilita. Cumplimos estrictamente una serie de normas federales y estatales relacionadas con la privacidad y la seguridad de la información, diseñadas para mantener segura su información.

CAMBIOS EN ESTE AVISO:

El DHS se reserva el derecho a modificar este aviso en cualquier momento. El nuevo aviso se aplica tanto a la información ya obtenida como a la que se reciba en el futuro. El DHS publicará una copia del aviso actual en nuestras oficinas 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 consulta sobre este aviso, póngase en contacto con:

Departamento de Servicios Humanos de Georgia
Responsable de protección de datos
47 Trinity Avenue SW,
Atlanta, GA 30334
HIPAADHS@dhs.ga.gov
(404) 463-0590

Si cree que se han violado sus derechos de privacidad, puede presentar un reclamo por escrito poniéndose en contacto con el responsable de protección de datos mencionado anteriormente. Por favor, incluya su nombre, número de teléfono, número de caso y una descripción de su reclamo. **No se lo sancionará por presentar un reclamo.**

También puede presentar un reclamo ante la Oficina de Derechos Civiles (OCR, en inglés) del Departamento de Salud y Servicios Humanos de los Estados Unidos. Para 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 HIPAA y las normativas sobre conjuntos de códigos y las normas de seguridad de la HIPAA propuestas, visite el sitio web del Departamento de Salud y Servicios Humanos de EE. UU.: 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.

Appendix K
Instructions For Completion of The Georgia Department of Community Health Third Party Liability Health Insurance Information Questionnaire Form DMA 285

A. 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.

B. 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.

Appendix L
Third Party Liability Health Information Questionnaire (DMA 285)

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

CASE NAME:_____ CASE NO:_____

ADDRESS: _____ SSN: _____

_____ PHONE NO:_____

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

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

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

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

Is policyholder an Absent Parent? ☐ YES ☐ NO

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

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

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

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

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

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

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

_____
(Policy Effective Date) (Policy Termination Date)

_____
(Employer Name) (Telephone Number)

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

Types of Coverage (circle those which apply)

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

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

Signed_____ Date_____
Member or Authorized Person

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

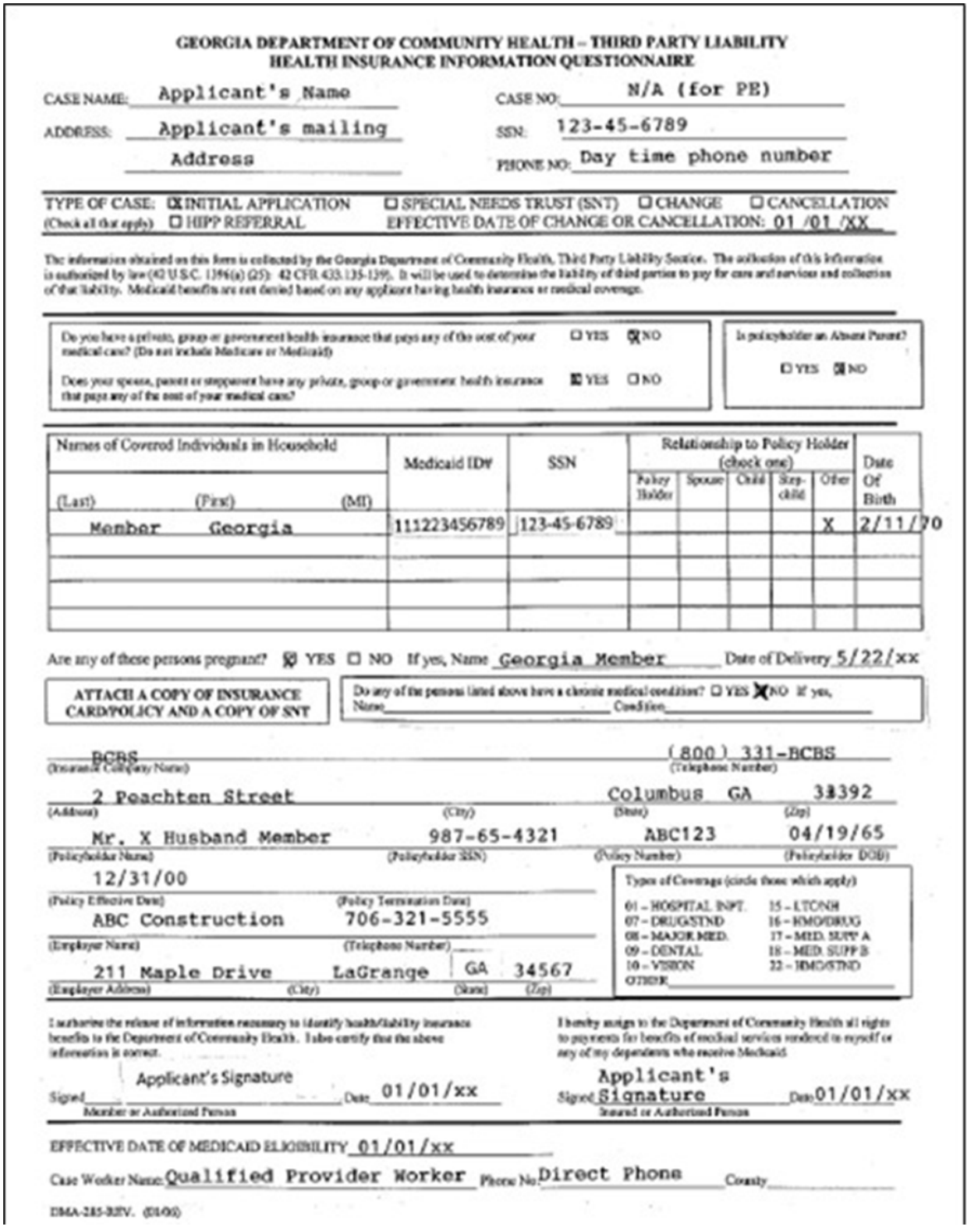
Signed_____Date_____
Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY_____

Case Worker Name:_____ Phone No:_____County_____

DMA-285-REV. (01/06)

Appendix L-1
Third Party Liability Health Information Questionnaire (DMA 285)-Example



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

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

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

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

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

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

Is policyholder an Absent Parent? ☐ YES ☒ NO

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

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

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

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

BCBS (Insurance Company Name) (800) 331-BCBS (Telephone Number)
2 Peachten Street (Address) Columbus (City) GA (State) 31392 (Zip)
Mr. X Husband Member (Policyholder Name) 987-65-4321 (Policyholder SSN) ABC123 (Policy Number) 04/19/65 (Policyholder DOB)
12/31/00 (Policy Effective Date) (Policy Termination Date)
ABC Construction (Employer Name) 706-321-5555 (Telephone Number)
211 Maple Drive (Employer Address) LaGrange (City) GA (State) 34567 (Zip)

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

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

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

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

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

EFFECTIVE DATE OF MEDICAID ELIGIBILITY 01/01/xx

Case Worker Name: Qualified Provider Worker Phone No: Direct Phone County_____

DMA-285-REV. (01/01)

Note: 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.

A. Instructions For Completion of The Georgia Department of Community Health Third Party Liability Health Insurance Information Questionnaire Form DMA 285

B. Purpose

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

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

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

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

Appendix M
Quick Guide on PE Medical Assistance

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor — Russel Carlson, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

Quick Guide on Presumptive Eligibility Medical Assistance

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

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

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

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

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

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

You will have a yearly renewal.

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

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

Revised 9/14/23

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

Equal Opportunity Employer

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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

Guía Rápida sobre Presunta Elegibilidad Asistencia Médica

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

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

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

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

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

Tendrás una renovación anual.

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

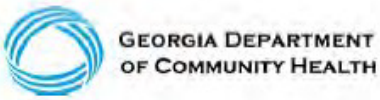
Si tiene preguntas sobre lo que cubre la Asistencia Médica , consulte a su médico o llame al: **1-866-211-0950**.

Revisado el 9/14/23

A. 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.

Appendix N
PE Manual Updates



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Russel Carlson, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

PRESUMPTIVE ELIGIBILITY MANUAL UPDATES

EMAIL TO DCH: pecorrections@dch.ga.gov TODAY'S DATE: _____
Subject Line: PE Manual Update

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

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

Name ☐ _____

Address ☐ _____

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

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

Number of Births ☐ _____

Terminate P4HB ☐

Add PE to GAMMIS ☐ **PE Period:** _____

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

Duplicate ID Merge: _____ Original _____ Duplicate

Race: ☐American Indian or Alaskan ☐Asian ☐Black ☐Caucasian ☐Hispanic ☐Other: _____ (specify)

Ethnicity: ☐Hispanic ☐N/A

Citizenship: ☐U.S. Citizen/U.S. National ☐Qualified Immigrant ☐Non-Qualified Immigrant ☐Other: _____ (specify)

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

_____ Name of QH/QP Employee

_____ QH/QP Employee Phone Number

CONFIDENTIALITY PROVISION

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

Revised 9/14/23

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

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A. 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 hpe.inquiries@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.

Appendix O
Notice of ADA/Sector 504 Rights (English/Spanish)

Notice of ADA/Section 504 Rights

Help for People with Disabilities

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

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

How to Request a Reasonable Modification or Communication Assistance

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

How to File a Complaint

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

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

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

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

Revised 12/09/2020

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

Ayuda para personas con discapacidad

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

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

Cómo solicitar una modificación razonable o asistencia de comunicación

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

Cómo presentar una queja

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

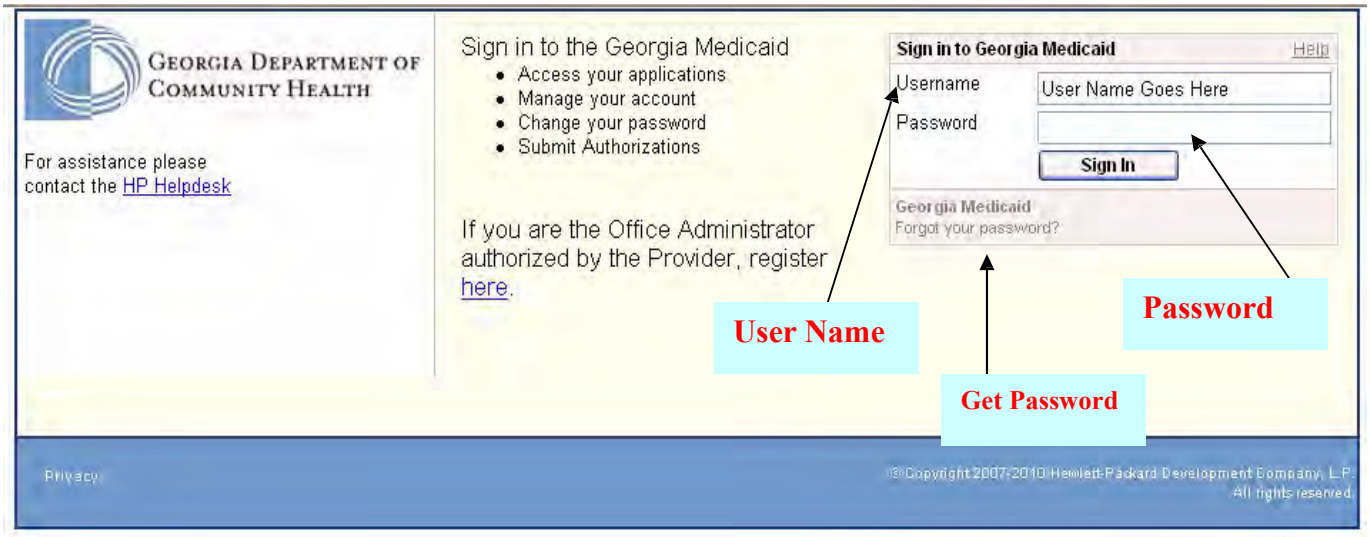
Puede pedirle a su asistente social una copia del formulario de queja de derechos civiles del DFCS. El formulario de queja también está disponible en: https://dfcs.georgia.gov/adasection-504-and-civil-rights. Si necesita ayuda para presentar una queja por discriminación, puede comunicarse con el personal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

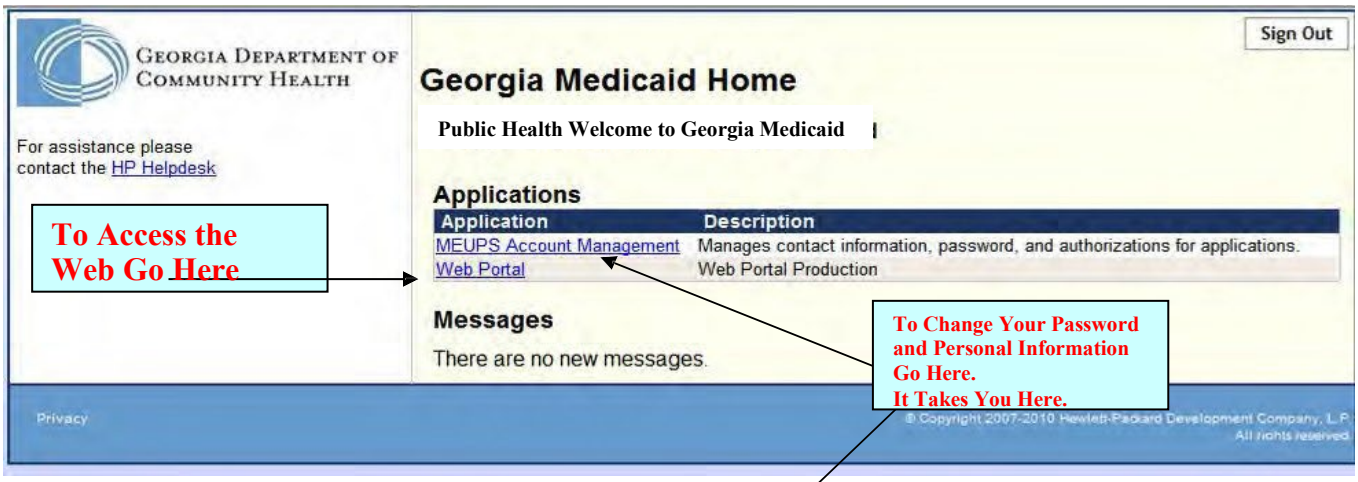
También puede presentar una queja por discriminación ante la agencia federal correspondiente. La información de contacto del Departamento de Agricultura de los EE. UU. (USDA) y del Departamento de Salud y Servicios Humanos de los EE. UU. (HHS) se encuentra dentro de la "Declaración conjunta de no discriminación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

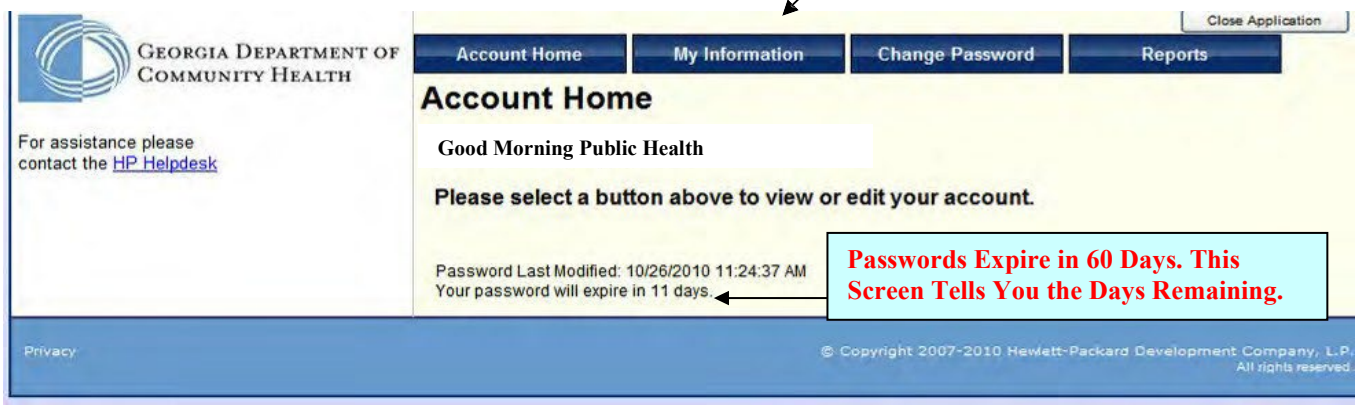
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Appendix P
GAMMIS

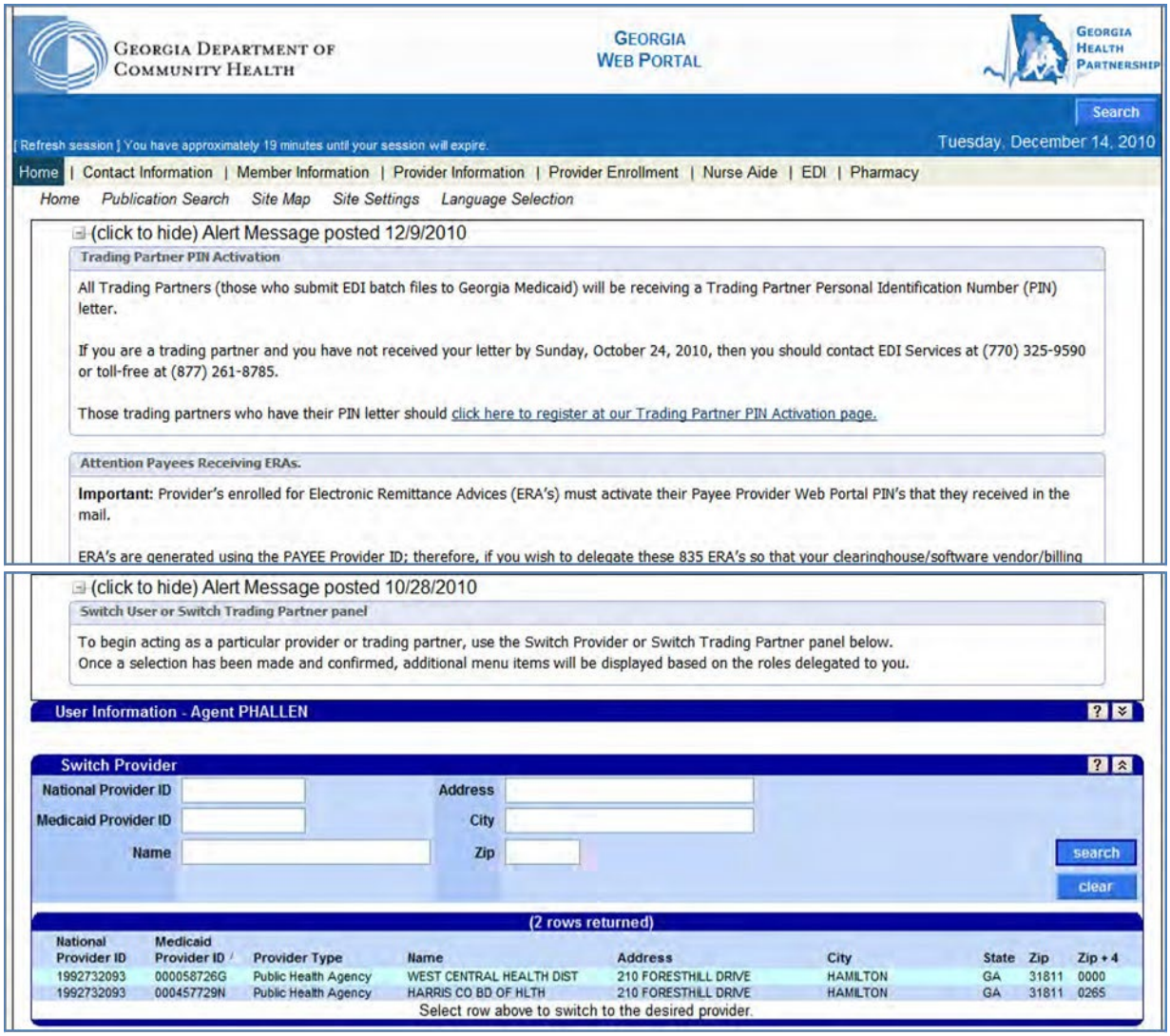
A. Sign on to GAMMIS:



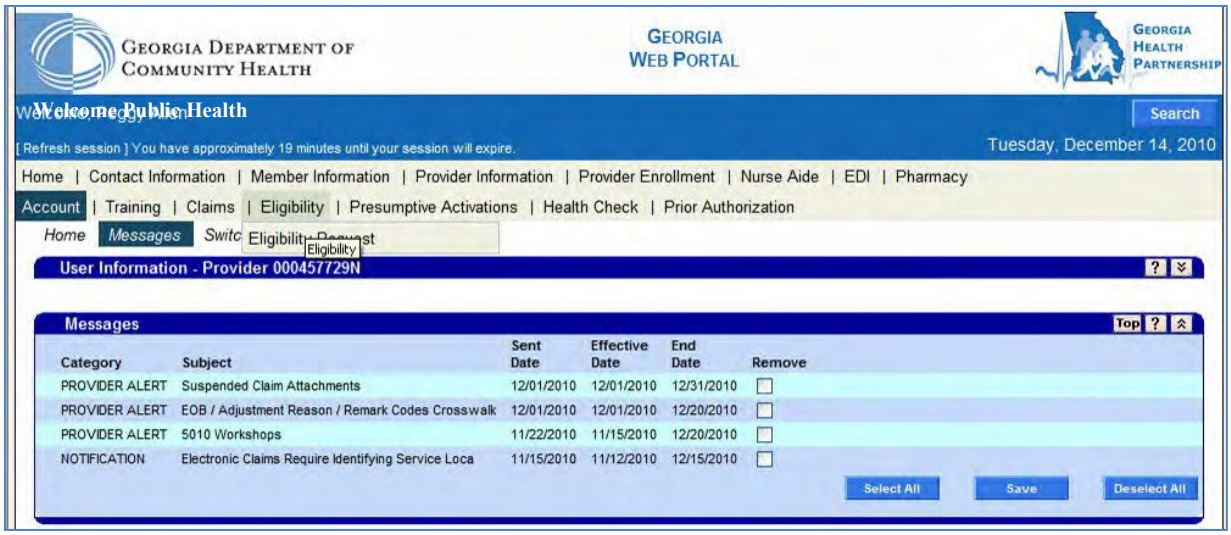




B. Going to the Web:

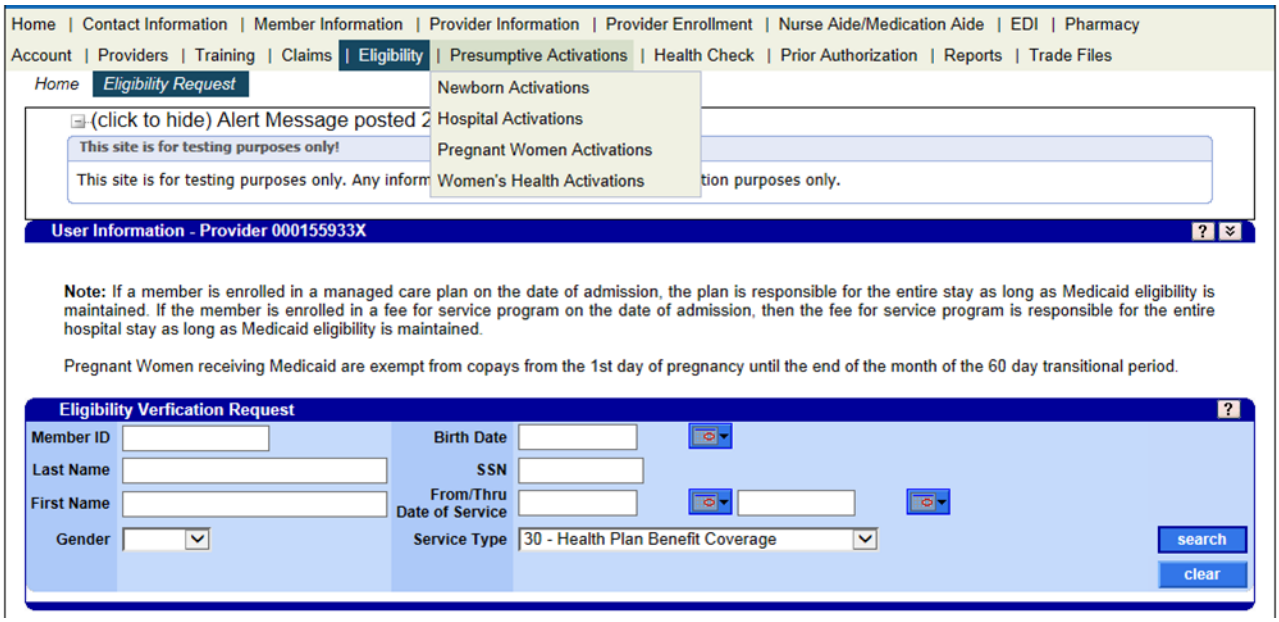


C. Messages:

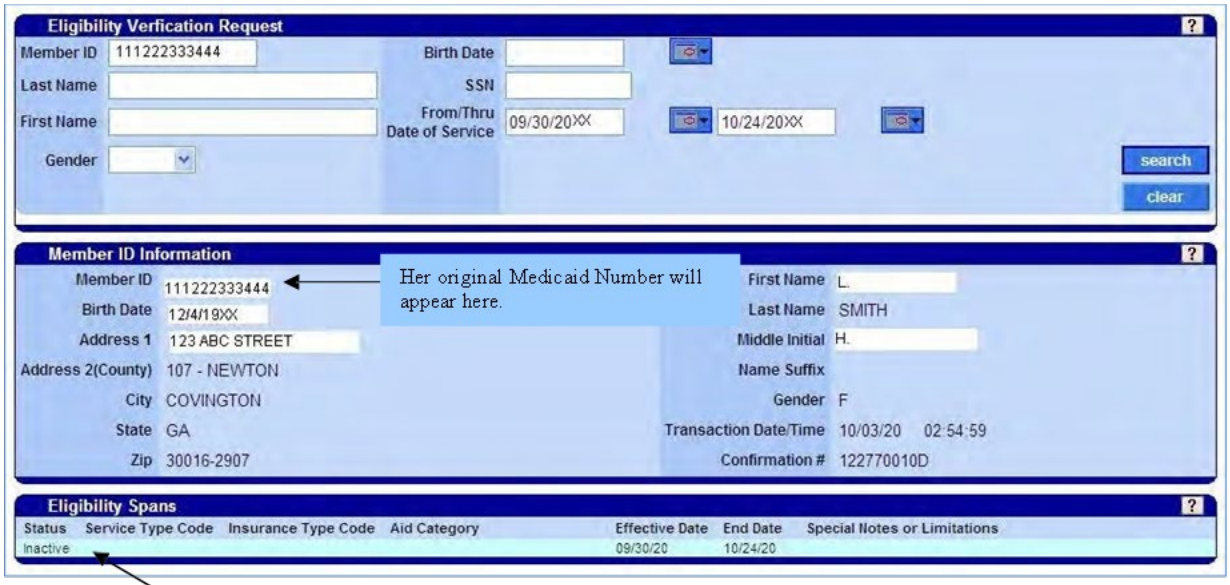


D. Screening on the web portal:

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



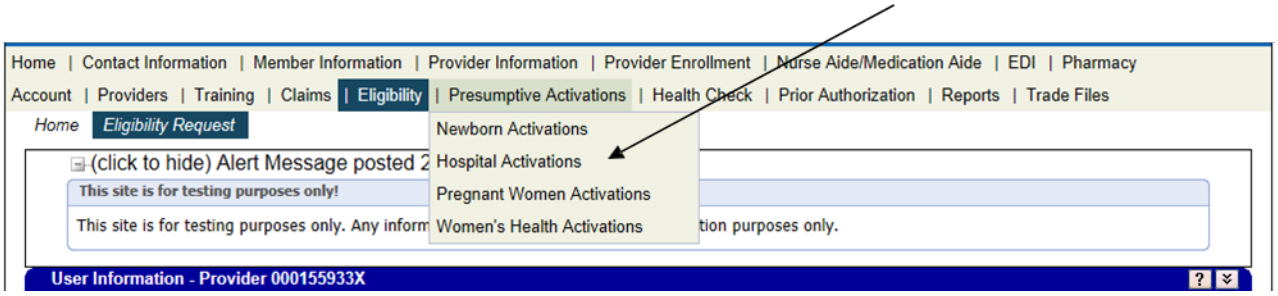
i. If the applicant was ever known to the system, you will see them as inactive at the bottom of the screen.



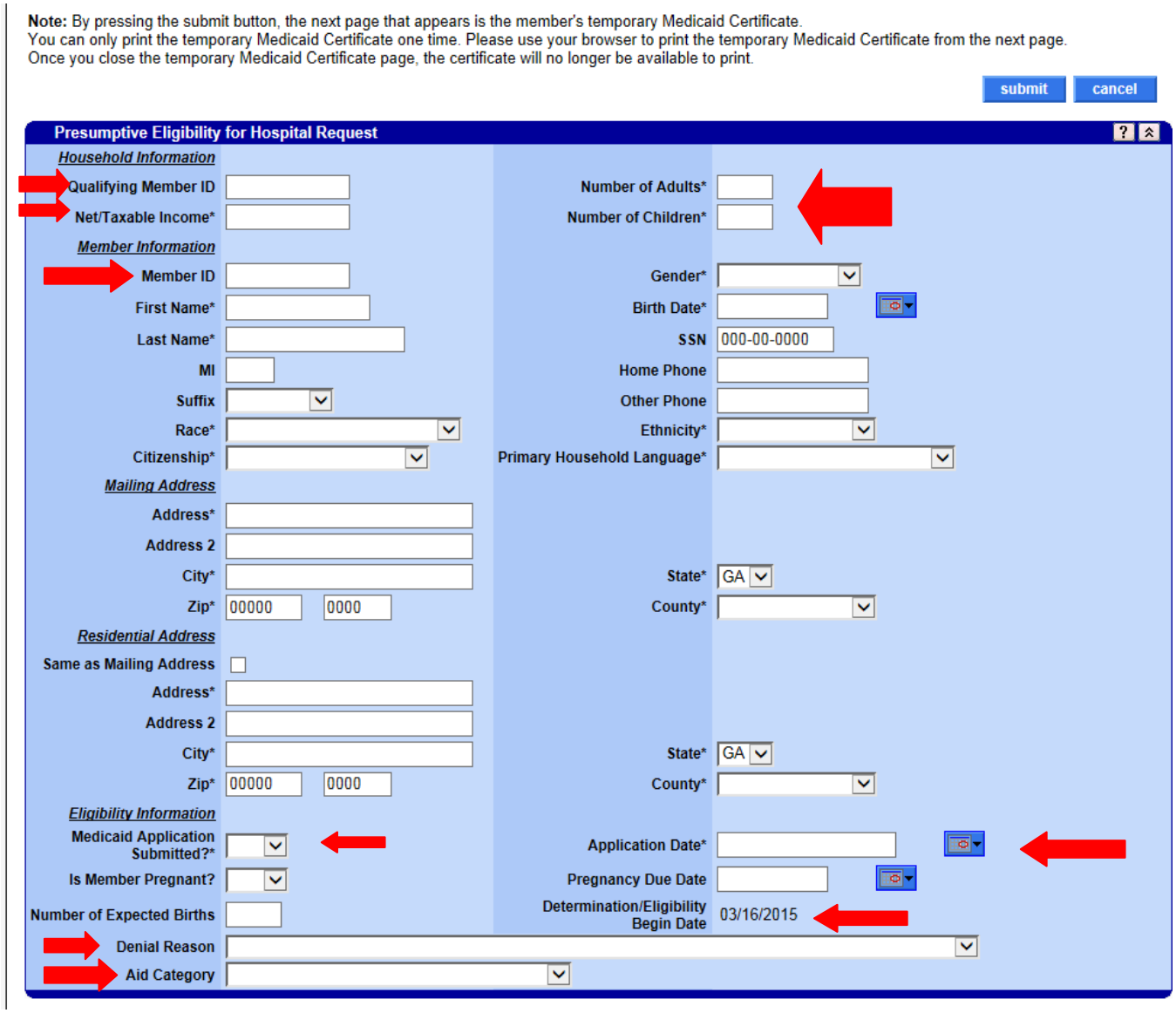
ii. If they have never had Medical Assistance this screen will not appear.

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

iv. 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:

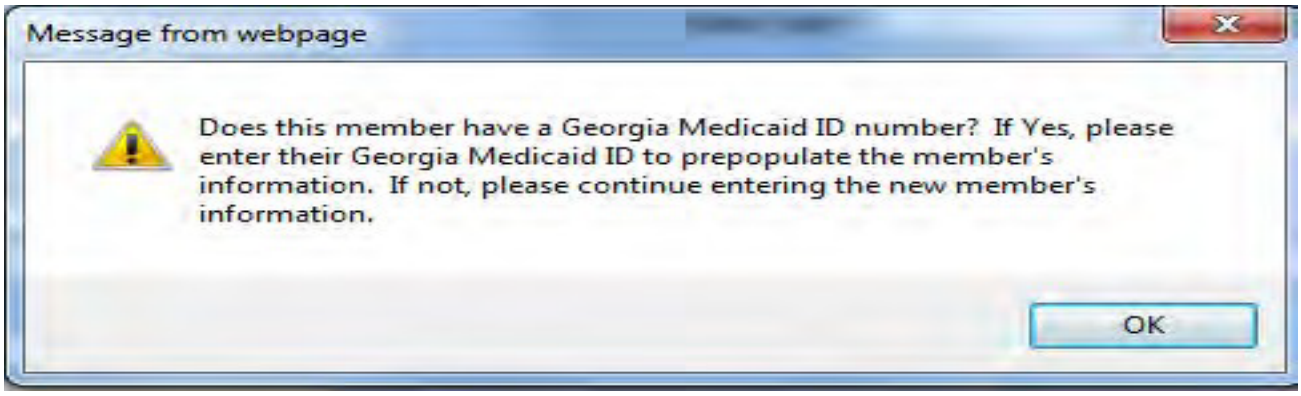


E. The Hospital PE Screen will appear:



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

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

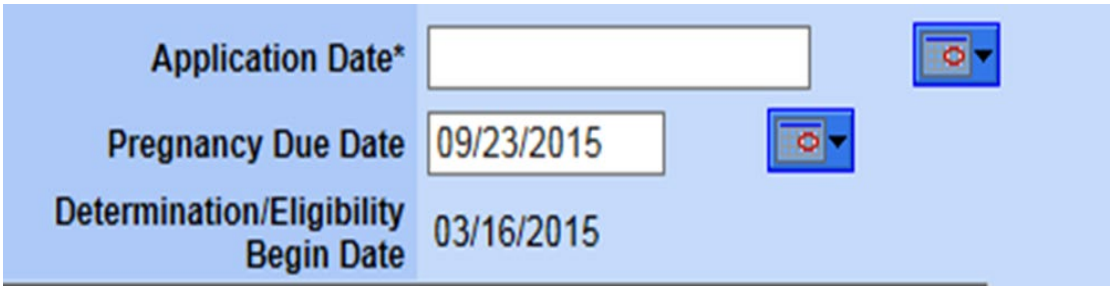


iii. All information can be changed except the First Name, Date of Birth (DOB) and Social Security Number (SSN). If this information needs to be corrected use the current PE Corrections Coversheet procedure after you enter the PE in the Web.

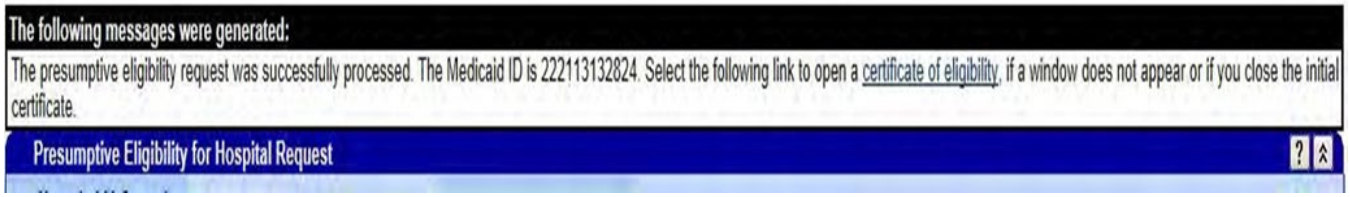
iv. Once you enter the Member ID number and the submit button you will receive this alert message:



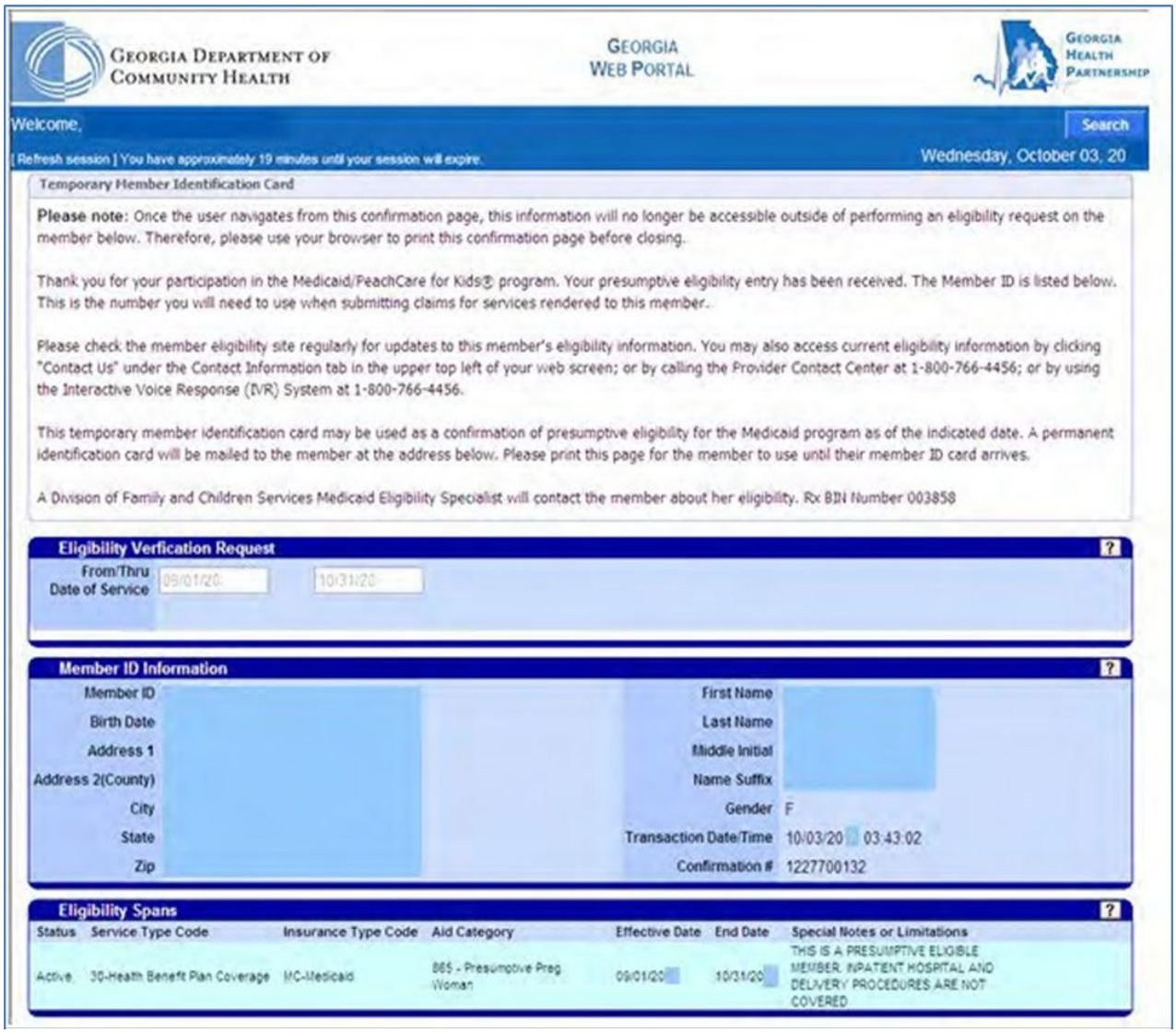
v. The applicant's last known information in GAMMIS will auto-populate. The Determination/Eligibility Begin Date field will pre-populate with today's date. This field cannot be modified.



vi. 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.



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



Appendix Q
Treatment of Income in Medical Assistance

A. Income

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

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.

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

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	
	Long Term Care Coverage - contributions by an employer to provide coverage for long-term services. This includes Archer MSA contributions.	E	
	Health Flexible Spending Arrangement (health FSA) - employer provided health FSA which will result in a reduction of salary and reimbursements of medical care.	E	
	Health Savings Accounts (HSA) - contributions made by the individual are deductions for tax returns.	E	
	Distributions from HSA that are used to pay medical expenses.	E	
	Distribution from HSA that are not used to pay medical expenses.	E	
	Contributions to HSA made by employers	I	
	Qualified HSA funding distribution-a onetime distribution from an individual retirement account (IRS) to an HAS.	E	
ADOPTION ASSISTANCE	Unearned – Payment received for the adoption of certain children. IV-E - Exclude as income.	E	E
	IV-B - Exclude as income.	E	E
ADVANCE	Unearned – Money for future expenses that does not represent a gain to the AU.	E	E
	Earned – A prepayment of wages or salaries.	I	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	I
ALASKA NATIVE CLAIM	Unearned – Payments made under Alaska Native Claims Settlement Act.	E	I
	Alaska Permanent Fund Dividend-payment from Alaska's mineral income fund.	I	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 (ABD and Non MAGI FM) E* (MAGI) *Divorces and separations finalized before 01/01/2019 consider Alimony as income for MAGI.	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
AMERICORPS	Income from Americorps Network of programs which encompasses: Americorps USA Americorps VISTA Americorps NCCC Are handled as specified below:		
	Living Allowance Stipend – Earned Income	E (ABD and Non MAGI FM) I (MAGI)	E
	On-the Job Training – Earned Income	E (ABD and Non MAGI FM) I (MAGI)	E
ANNUITY	Unearned – Recurring payment received from an investment. Refer to 2339 Annuities.	I	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	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 (ABD and Non MAGI FM) E (MAGI)	I
BLOOD, sale of	Earned – Money received from the sale of blood including blood products.	I	I
BOARDER INCOME	Earned – Direct payments for food and related shelter expenses, less the cost of doing business.	I	I
BONUS	Earned – Wages paid in addition to the usual or expected wages. Refer to Wages in this chart.	I	I
CAPITAL GAINS	Earned or Unearned – profits from the sale of capital goods or equipment. Capital assets are resources such as stock, securities, real estate and equipment that are typically held as an investment for a period of time. A capital gain is realized when the item(s) sold have appreciated in value from the original purchase price.	I	I
CENSUS INCOME	Earned - All wages paid by the Census Bureau for temporary employment related to Census activities.	E (ABD and Non MAGI FM) I* (MAGI) *As of 01/01/2019	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATION NOT STATE / FEDERALLY FUNDED	Unearned – Charitable donation paid to the AU or BG.	E	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	I
CHILD CARE ATTENDENT (wages earned by)	Earned – income received for providing child care services. Consider the income as follows: • Self-employment if the attendant provides child care services in his/her home • As wages if the attendant provides services in the home of the child.	I	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	E
CHILD NUTRITION PAYMENTS	Unearned – The value of meals provided to a child in day care through the Child Nutrition Amendment of 1978. *If the payment is for a child of the attendant, budget the entire amount as unearned income. If the payment is for any other child, treat as self-employment income. Refer to the Section 2415, Self Employment.	*I	I
CHILD SUPPORT	Unearned – Income received for the support of child (ren) from the non-custodial parent of the child. Child support paid for a child by a non-custodial parent is always income to the child and never to a parent/ relative/ guardian. *If an ABD child (including LA-D A/Rs) receives child support from a non-custodial parent exclude from the eligibility budget 1/3 of the monthly child support received.	I* (ABD) I (Non MAGI FM) E (MAGI)	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CHILD'S EARNINGS Children in Placement	Earned – Income earned by a child, including MAGI Medical Assistance under 19 years old and for CW-FC children to 21 years. *Refer to Section 2610 to determine when Child's Earnings should be counted. Reference Section 2835, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria for children in care.	I (ABD) E* (MAGI and Non MAGI FM)	E
CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS	Unearned – income paid by the U.S. Civil Service and Federal Employee Retirement System (FERS) through the Office of Personnel Management (OPM) because of disability, retirement or death. Certain disability benefits paid within the first 6 months that an employee last worked are earned income. Use notices or other documents in the individual's possession (other than a check) to verify the gross amount of the payment. Notices providing the amount of the annuity and the adjusted amount of the annuity are reliable evidence of the gross amount. If an individual's records are unavailable, complete Form 990, Benefits Verification, and direct the inquiry to the following address: Office of Personnel Management Retirement and Insurance Coverage 1900 E. Street, NW Washington, D.C. 20415	I	I
COMMISSION	Earned – A payment, usually a set fee or percentage, made to an employee for his/her service in facilitating a transaction such as buying or selling goods. A commission may be paid in lieu of or in addition to a regular salary. Refer to Wages in this chart. If the payment is recurring, include it when determining representative pay. If not, do not include the pay. Refer to Section 2653, Prospective Budgeting.	I	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

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CONTRIBUTION, GIFT, PRIZE, AWARD	Unearned – Money given to the AU as a gift from individuals or organizations. *ABD: If the contribution is in the form of food, clothing or shelter, value the contribution as ISM, including third party vendor payments resulting in food, clothing, or shelter to the A/R. Never include ISM as income for an A/R in LA-D.	*I (ABD) I (Non-MAGI FM) E (MAGI)	I

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

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
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	I
DISABILITY	Unearned – Paid by insurance company or a source other than an employer. Refer to Sick Pay in this chart.	E (MAGI) I (ABD and Non-MAGI FM)	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 FM) I (MAGI)	E
DIVERTED INCOME FOR FAMILY MEDICAL ASSISTANCE Children in Placement	Unearned – Money deducted or diverted by a court order to a third party.	E	N/A
	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.	I	N/A
	Benefits/support (child support, SSI, RSDI, etc.) of a child in care diverted to the county of custody as designated payee for the benefit and care of the child and are considered the child's benefits/support. Refer to specific type of income for treatment of income.		N/A
DIVERTED INCOME FOR ABD MEDICAL ASSISTANCE	Unearned - Income diverted to a spouse or dependent family member from a NH or CCSP A/R. Include as unearned income to the spouse or dependent family member (DFM) to whom the income is diverted in the eligibility and CCSP/ICWP cost share budgets, if the spouse/DFM is a Medical Assistance A/R. Refer to Section 2554, Diversion of Income.	I	I
Spouse or Dependent Family Member A/R	Include as unearned income to the A/R from whom the income is diverted in the eligibility budget. Allow as a patient liability/cost share budget deduction. Verify from the NH, CCSP or A/R's case record. Diverted income is included in PL when a community spouse enters LA-D. Refer to Spousal Impoverishment budgeting.	I	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
DIVIDENDS	Unearned – A share of profits received by a policy holder or shareholder. Any dividends left to accrue are a resource separate from the resource that is earning dividends. • For ABD, any dividends earned on countable resources are not counted as income. • For non-FBR COAs, dividends earned on excluded life insurance policies are excluded as income. *For Family Medically Needy, dividends earned on life insurance policies are a countable resource. Non-participating life insurance policies do not earn/pay dividends. Use Form 106 or other acceptable documents to verify dividends.	*E	*E
DOMESTIC VOLUNTEER SERVICES PAYMENTS	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 certain low income working taxpayers. This tax credit may or may not result in a payment. EITC payments can be received as an advance from an employer or a refund from IRS. EITC given as a tax credit (no payment) is not income.	E	E
EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS (Title IV of Higher Education Act Programs)	UNEARNED - Payments for the educational assistance of an AU member enrolled at a recognized institution of post-secondary education, school for the handicapped, vocational program or a program that provides for completion of a secondary school diploma or GED. These programs include Pell grants, State Student Incentive Scholarships, Work-Study programs, etc. Unearned – payments from educational assistance to the A/R. Exclude, regardless of use.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EMERGENCY ASSISTANCE (IV-A)	Unearned – payments for children, including families with children, provided by the state and matched with federal funds. Emergency Assistance is used to meet emergency needs and is not IBON or ABON. Georgia does not provide Emergency Assistance payments.	I	I
EMPLOYEE RETIREMENT BENEFITS	Unearned – Individuals/surviving spouse may be eligible for retirement benefits based on previous employment. Explore if the A/R or spouse worked 10 or more years for the same employer.	I	I
ENERGY ASSISTANCE PAYMENTS	Unearned – Payment or allowance received under federal, state, and local law for the purpose of assisting the AU with the cost of heating and cooling its home. These include HUD and FMHA Utility reimbursements.	E	E
FARM ALLOTMENTS	Unearned – Payments from government sponsored programs such as Agricultural Stabilization and Conservation Services which are a gain or a benefit to the AU.	I	I
FARMING	Earned – Income received from agricultural labor. Refer to Section 2415, Self Employment.	I	I
FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS	Unearned – food and shelter assistance provided in cash or in kind in emergency disaster situations. Exclude if the assistance is designated as home energy assistance or support and maintenance assistance. Otherwise, contact the State Medicaid Policy Unit for further instructions.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
FEDERAL PROGRAMS, MISCELLANEOUS	• Federal Housing Assistance • Food Stamps • Food Programs with federal involvement for Older Americans • Refugee Cash Assistance, Cuban and Haitian • Entrant Cash Assistance and federally reimbursed general assistance payments to refugees • Refugee reception and placement grants and refugee matching grants • Relocation Assistance Contact the State Medicaid Policy Unit if there is a payment that is not on this list and it is questionable as to whether it should be excluded or counted.	E	E
FLEXIBLE BENEFITS	Earned – Refer to Wages in this chart.	I	I
FOSTER CARE PAYMENTS (IV-B or Title XX)	Unearned – per diem payments received by the foster parents to provide for the needs of the foster child and foster family.	E	E
FOSTER CARE PAYMENTS (IV-E)	Unearned – per diem payment received to provide for the needs of the foster child. Exclude as income to the foster child.	E	E
FOSTER GRANDPARENTS PROGRAM PAYMENTS	Unearned – payments received for voluntary service under the federal government (ACTION)	E	I
GARNISHMENT	Earned/Unearned – A set amount of wages or monies withheld by an employer/entity to pay a debt owed to a third party.	I	I
GUARDIANSHIP, ENHANCED SUBSIDIZED AND SUBSIDIZED	Financial support for a child who was in the custody of DHR and guardianship is awarded to a relative or non-relative foster parent(s). Income is not attributed to the child. Reference Section 2848 – Relative Care Placement for additional information.	E	E
GENERAL ASSISTANCE (GA) PAYMENTS	Unearned – payments received by the A/R from county funds administered by DFCS. Consider as Assistance Based on Need (ABON).	E	E
GENERAL ASSISTANCE VENDOR PAYMENTS	Unearned – GA paid directly to the provider if paid for housing expenses including GA paid for transitional housing for the homeless and if paid for energy or utilities.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
GRANDPARENTS RAISING GRAND-CHILD - REN EMERGENCY / CRISIS INTER-VENTION SER-VICES	TANF lump sum payment in the amount of three times the eligible grant amount for the AU size. This payment is used to help pay for the cost of emergent needs incurred by the grandpar-ents when the children come to live with them. *For ABD, do not deem GRG income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	I
GRANDPARENTS RAISING GRAND-CHILD - REN SUBSIDY PAY-MENT	UNEARNED - TANF Subsidy in the amount of $50.00 per child per month used assist low income (fixed income) grandparents (60+) to cover additional expenses associated with rearing their grandchildren. *For ABD, do not deem GRG income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	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 Grandpar-ent Payee's ABD budget	*	*
HEALTH REIM-BURSEMENT ACCOUNT	An account through an employer which may only be used to reimburse individuals for cer-tain medical services. *Count any income received in excess of the incurred expense(s) as unearned income.	*E	*E
HOME PRODUCE	Unearned – home produce used for personal consumption and not offered for sale.	E	E
HOUSING AND DEVELOPMENT (HUD) RENTAL REFUND	Unearned – Payment received by the AU for rent. Payments are often distributed by the Georgia Residential Financial Authority (GRFA). Payments can be made directly to the AU, by a two-party check or directly to the landlord on behalf of the AU.	E	E
HOUSING AND URBAN DEVEL-OPMENT (HUD) OR FARMERS HOME ADMINIS-TRATION (FMHA) UTILITY REIM-BURSEMENT	Unearned – Utility reimbursement provided by HUD and FMHA to AUs who receive hous-ing assistance and are responsible for paying their utilities separately from their rent. Payments can be paid directly to the AU, by a two-party check or directly to the utility com-pany on behalf of the AU.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
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.). 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.	See specific type of IBON	See specific type of IBON
INCOME TAX REFUND	*Refer to the Chapter 2300, Resources, to determine how to count income tax refunds. For how to count in PL/CS, refer to Section 2552, PL/CS Deductions.	*	*
INDIAN LAND GRANTS	Unearned – Federal distributions to members of Indian Tribes.	E	E
INDIAN GAMBLING ACT PAYMENTS	Tribally managed gaming revenues *If the funds have NOT been held in trust by the Secretary of the Interior, count as unearned income. If held in trust by the Sec. of Interior, exclude.	*	*
INHERITANCE	Unearned – cash, a right or non-cash item(s) received as a result of someone's death. Exclude expenses for the last illness & burial of the deceased if paid by the inheritor. Until an item or right has a value or is accessible, it is neither income nor a resource.	I	I
IN-KIND ITEMS RECEIVED IN LIEU OF WAGES	Earned – Wages may include the value of food, clothing, shelter or other items provided in lieu of cash wages.	I (ABD) E (MAGI and Non MAGI FM)	E
IN-KIND SUPPORT AND MAINTENANCE	Unearned – Any gain or benefit that is not in the form of money payable directly to the AU such as meals, clothing, produce or housing. *Refer to Section 2430, Living Arrangements and In-Kind Support and Maintenance.	*I (ABD) E (MAGI and Non MAGI FM)	E
INSURANCE BENEFITS DUE TO LOSS OF INCOME	Unearned – benefits paid from an insurance policy due to loss of income. *Refer to Section 2230, Third Party Resources, for information on benefits paid to cover medical expenses.	*I	*I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
INTEREST	Unearned – Income paid from bank account deposits, life insurance or other financial instruments/investments. FAMILY: Annualize for prospectively budgeted AUs to determine a monthly amount. *Exclude amounts of $1.00 or less per month. ABD: The following types of interest earned on countable resources are excluded as income in the eligibility and PL/CS budgets: • Interest earned on all countable financial instruments, such as checking/savings accounts, CDs, etc. • Interest earned on countable Patient Fund Accounts. *Exception: Interest portion of payment made on contracts are counted as income. If total interest earned on excluded resources is $20/month or less, exclude in the Medical Assistance eligibility and AMN spenddown budgets. If total interest earned on excluded resources exceeds $20/month, include all the interest in the eligibility and spenddown budgets. See exceptions below.	*I (MAGI and Non MAGI FM) *E (ABD)	E*
INTEREST Burial Contracts Burial Funds	Exclude interest earned on the excluded portion of a burial contract for FBR A/Rs.	E	E
	Exclude all interest earned on a burial contract for non-FBR A/Rs if left to accrue.	E	E
	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

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
IRREGULAR / INFREQUENT INCOME	Earned and Unearned – Income that is received too infrequently or irregularly to be anticipated, regardless of the amount. Refer to Section 2504 for definition of irregular or infrequent income. Treat such income as the following: Earned income of $30 or more received over a three month period	I	I
	Earned income of less than $30 received over a three month period	E (ABD) I (MAGI and Non MAGI FM)	I
	Unearned income of less than $60 received over a three month period	E (ABD) I (MAGI and Non MAGI FM)	I
	Unearned income of $60 or more received over a three month period	I	I
JAPANESE – AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS (PL 100-383)	Unearned – Restitution payments made by the U.S. Government to Japanese-Americans and Aleutians or their survivors as a consequence of their evacuation, relocation and internment during World War II.	E	E
JURY DUTY	Earned – Compensation received for serving on a jury.	I	I
LOANS FROM OTHERS (PERSONAL OR BUSINESS): A/R is making payments	Unearned – Money received that the borrower has an obligation to repay. Requires a prepayment agreement (written or oral).	E	E
LOANS TO OTHERS (Payment made to A/R)	Unearned - Money loaned to persons outside the AU where a repayment agreement exists. Payments received are considered income. *ABD refer to Section 2313.	I*	I*
LOTTERY WINNINGS	Unearned – A sum of money received as a result of purchasing a winning ticket in a game of chance. *Refer to the appropriate sections on Lump Sum budgeting for Family or ABD Medical Assistance and also refer to note in Section 2405.	*	*

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
LUMP SUM Children in Placement	Unearned – A sum of money that is received at one time. This may be an accumulated amount or a one-time occurrence. *Count as income in month of receipt. Any remainder is counted as a resource beginning the month after receipt (refer to Resources Chart 2399.1, Lump Sums). For all AFDC related categories of Medical Assistance, a lump sum is treated as income in the month received and as a resource in any amounts thereafter.	*	*
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.	I (ABD) I (MAGI and Non MAGI FM)	I
	Unearned – Money received by the AU for the care and maintenance of an individual not in the AU. Include as income to the individual entitled to the income. Exclude as income to the protective payee. Exclude as income to the AU if the protective payee is not making payments to or for the AU.	I (ABD) I (MAGI and Non MAGI FM)	I
MILITARY ALLOTMENTS	Unearned – payments received for quarters, rations, and clothing are subject to deeming. In ABD, Furnished on-post housing is subject to the PMV rule as ISM but is not subject to deeming. *In Family, consider the income as child support if for a dependent child. Only base pay is earned income. (This would be excluded for MAGI COAs)	I	I
MILITARY PAY	Military personnel benefits as reported on Leave and Earnings Statement (LES). Refer to Section 2420, Military Pay.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
MILITARY RETIREMENT	Unearned – income received by military retirees and survivors. Beneficiaries who may be entitled to receive military payments include the retiree, his/her surviving spouse and children. Direct inquiries to the Military Finance Centers as shown below: Air Force Parallel FO: 388 AFAFC/XSP Denver, CO 80279 Army USAFAC Director, Retired Operations Indianapolis, IN 46246 ATTN: Management Support Office Marine Corps Parallel FO: D24 Marine Corps Finance Center 1500 E. 95th Street Kansas City, MO 64197 Navy Parallel FO: D24 Retired Pay Department Code 305, Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199	I	I
MILITARY RETIREMENT LUMP SUM	Unearned – Consider as unearned income in the month or receipt. Treat as a resource the month following the month of receipt.	I	I
MONTGOMERY GI BILL PAYMENTS	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. Any portion of funds that come from the individual's earnings is counted as income.	E	E
NATIONAL EMERGENCY GRANT (DISASTER RELIEF EMPLOYMENT)	UNEARNED - Grants funded by FEMA, used to provide disaster relief employment on projects that provide food, clothing, shelter and other humanitarian assistance for disaster victims.	E	E
NATIONAL FLOOD INSURANCE PAYMENTS	UNEARNED - Payments made for flood mitigation activities under the National Flood Insurance Act of 1968.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
NOISE ABATEMENT PAYMENTS	Unearned – Non-recurring payment designated for noise abatement work on a dwelling.	E	E
OLDER AMERICANS ACT / SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM	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 than a wage or salary is excluded income.	I (ABD) E (MAGI and Non MAGI FM)	I
OVERTIME PAY	EARNED - Extra income paid to employees who work in excess of 40 hours in a week. Refer to Wages in this chart.	I	I
PENSIONS	Unearned – A payment received regularly as a retirement benefit.	I	I
PUBLIC LAW 103-286 - PAYMENTS to VICTIMS of NAZI PERSECUTION (examples, including but not limited to the following: German Reparation, German Pensions for Work in Ghettos	Unearned – any payments made to individuals because of their status as victims of Nazi persecution under Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 Such payments are disregarded in determining eligibility for any amount of benefits/services provided under any Federal or federally assisted program based on need.	E	E
Qualified Income Trust (QIT)	Income placed in a QIT allows for income eligibility under ABD LA-D COAs. Refer to Section 2407.	MAGI and Non MAGI FM – N/A ABD LA-D COAs – E All other ABD COAs – N/A	I
Qualified Tuition Savings Programs (529 Plans)	A savings plan for higher education. Refer to Section 2344.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RAILROAD RETIREMENT (RR)	Unearned – retirement, survivors or disability income paid to former railroad employees and/or their dependents. Use gross RR and/or RSDI, including the amount paid as a Medicare premium. *For ABD, refer to Section 2552, Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget. Consider a benefit augmented for dependents as income to the beneficiary, not the dependent. If the A/R's SSN begins with a 7, the individual is likely to be eligible for RR. If the A/R's deceased spouse worked for a railway system, the A/R may be eligible, even if remarried. RSDI and RR may be combined in one check. If so, verify RSDI via SSA and RR through the Railroad Retirement Board. To obtain written verification of the benefit amount, complete Form 990 and mail to: [%hardbreaks] Benefits Verification Railroad Retirement Board 401 W. Peachtree Street, Room 1702 Atlanta, GA 30365-2550	I	*I
REFUNDS FROM DCH	Unearned – A refund of excess proceeds from a TPL after Medicaid and the TPL have paid a medical expense claim in full.	I	I
REIMBURSEMENT	Unearned - Payment for an expense that does not represent a gain or benefit to the AU.	E	E
RELATIVE CARE SUBSIDY	Unearned - Financial support for children placed with an approved relative caregiver. A child may or may not be in DFCS custody for relative caregiver to qualify for certain subsidies.	E	E
RELOCATION ASSISTANCE	Unearned – Money paid under Title II of the Uniform Relocation Assistance & Real Property Acquisition Policies Act of 1970.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RENTAL INCOME	Earned or unearned – Money received on property owned by an AU member and rented to others. Earned – Must be engaged in management of property an average of 20 hours per week. Unearned – If not involved in management more than 20 hours per week.	I Family - May deduct expenses from maintaining and handling of property	I May deduct expenses from maintaining and handling of property
REPAYMENT OF OVERPAYMENT OF BENEFITS THROUGH BENEFIT REDUCTION IN TANF, SSI, RSDI, UCB (or others)	FAMILY: Unearned – Money withheld from the income source to repay a previous overpayment. Do not count the repayment amount. Count the gross minus the repayment amount. *ABD: Refer to RSDI Recoupment Amount and SSI Recoupment Amount in this chart.	E (MAGI and Non MAGIFM) 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

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI) (Also referred to as TITLE II BENEFITS or Social Security Benefits)	Unearned – Social Security benefits paid to an insured worker or dependent on the basis of the retirement, death or disability of the worker. Use the gross entitlement (before the Medicare Part B premium is deducted) in the eligibility budget. *For ABD, refer to 2552 Patient Liability/Cost Share Deductions for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget. Count the entire RSDI lump sum payment as income for the month of receipt. Refer to Chart 2399.2 – Resource Treatment of Income Retained after the Month of Receipt, for instructions on how to treat any portion of a RSDI lump sum retained after the month of receipt. Do not count refunded Medicare Part B premiums as unearned income. *For MAGI COAs RSDI of a tax dependent/child who has no other source of income AND resides with a parent is **excluded**. RSDI for a tax dependent/child is countable **only** if the tax dependent/child has other income that meets the IRS tax filing threshold **or** if the child does not reside with a parent and is not claimed as a tax dependent by his/her parent. Refer to Section 2610.	I (ABD and Non-MAGI FM) I* (MAGI)	I*
REVERSE MORTGAGE	Unearned – allows a homeowner to borrow, via a mortgage contract, a portion of the appraised value of the home. The homeowner then receives a periodic payment (or a line of credit) which does not have to be repaid as long as the borrower lives in the home. Reverse Annuity Mortgages (RAMs) involve the purchase of an annuity. In most reverse mortgages, the original loan does not need to be repaid until the homeowner dies, sells the home, or moves. The HEC plans connected with HUD through the Federal Housing Authority are reverse mortgages.		
	Treat as loan proceeds	I	
	Annuity payments from a RAM	E	
ROOMER	Earned – Direct payments for room only.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RSDI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly RSDI check by SSA to recover an overpayment of RSDI benefits to the individual *Refer to Repayment of Overpayment of Benefits on Page 2499-22.	I (ABD) E* (MAGI and Non MAGI FM)	E
SALE – LEASEBACK	Unearned – the homeowner transfers title of the home to a buyer (e.g., an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. The difference between payments on the installment note and the rental cost provides the former homeowner with cash. Under this arrangement, the buyer is responsible for the payment or real estate taxes, major maintenance, and casualty insurance. Some sale-leaseback arrangements involve the purchase of an annuity.		
	Treat as the conversion of a resource, not as income.	E	E
	Interest earned from an installment note	I	I
	Annuity payments	I	I
SCHOOL LUNCH PROGRAM	UNEARNED - The cash value of assistance provided to children under the National School Lunch Program, Child Nutrition Act, Special Milk Program, or School Breakfast program.	E	E
SELF EMPLOYMENT EARNINGS (NET)	Earned – income from a self-employed enterprise. Refer to 2415 Self-Employment.	I	I
SENIOR COMPANION PROGRAM	Unearned – payments to volunteers under a federal government program	E	I
SEVERANCE PAY	Earned – Money received from former employer upon termination of employment. Unearned - payments received from a former employer after termination of employment.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
SHARED HOUSEHOLD EXPENSES	Payments made to an AU by a person who shares household expenses, and which do not represent a gain or benefit to the AU. Consider UNEARNED income for Family Medical Assistance. Refer to 2430 Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid.	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.	I	I
	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	
	Earned – If paid from employer's payroll.	I	
	Unearned – Paid by insurance company or a source other than an employer.	E (MAGI) I (ABD and Non-MAGI FM)	
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

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
SUPPLEMENTAL SECURITY INCOME (SSI)	Unearned – monthly payments made to aged, blind or disabled individuals from the federal government. SSI is administered by the Social Security Administration. Consider as Income Based on Need (IBON). SSI recipients also receive Medical Assistance. *For ABD, do not deem the ineligible parent or spouse's SSI income to the A/R. However, include SSI in the Couple eligibility budget when one member of the couple is AMN and the other receives SSI. **Refer to 2578 SSI Recipients for information on including SSI income in nursing home patient liability budgets.	*I (ABD) E (MAGI and Non MAGI FM)	**I
SSI RECOUP-MENT 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. *Exclude a SSI recoupment from a SSI check, but include a SSI recoupment from an RSDI check, in the patient liability budget. For Family Medical Assistance, refer to Repay-ment of Overpayment of Benefits through Benefit Reduction in TANF, SSI, RSDI, UCB or others on page 2499-22-23.	I (ABD) E (MAGI and Non MAGI FM)	*I
SUSAN WALKER VS BAYER COR-PORATION SET-TLEMENT PAY-MENTS	A cash settlement as a result of a class action lawsuit. Unearned	E	E
TAX REFUNDS	A refund of taxes paid on food, income or property. It may be considered as earned or unearned.	E	*
	Earned - A refund of federal or state taxes paid on income.	E	*
	Unearned - A refund of taxes paid on food or property, such as real property or automo-biles. Refer to 2405 Treatment of Income. *Refer to 2552 Patient Liability/Cost Share Deductions.	E	*

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments. TANF benefits received from another state are budgeted for the month of receipt only. *For ABD, do not deem TANF income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	I
TIPS	Earned – Voluntary payments above the stated cost of a product or service given in appreciation for the service rendered. Refer to Wages in this chart.	I	I
TRADE READJUSTMENT ALLOWANCE (TRA)	UNEARNED - Weekly payment available for up to 52 weeks after an individual's UCB is exhausted and during a period in which the individual is participating in a full-time training program approved in accordance with the Trade Act.	I	I
TRAINING ALLOWANCES / STIPENDS (Refer to WIA for treatment of WIA income)	Earned – Payments received from vocational/rehabilitation programs recognized by Federal, State, local governments to the extent they are not a reimbursement or specifically excluded. If the earnings belong to a child, refer to Child's Earnings in this chart.	I	I
TRANSITIONAL SUPPORT SERVICES (TANF)	UNEARNED - TANF support payment used to pay for or reimburse the cost of childcare, transportation, and incidental expenses to an applicant or recipient. TSS is available for a period of six months beginning with the first month of TANF ineligibility. *For ABD, do not deem WSP income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	I
TRUST FUND PROCEEDS	Unearned – Money in a trust fund. *If the trust is not a Medicaid Qualifying Trust (MQT), include as income only those trust proceeds actually provided to the A/R by the trustee.	*I	*I
	*If the trust is an MQT, refer to 2336 Trust Property, Medicaid Qualifying (Prior to OBRA '93) for information on how to treat the trust proceeds. Verify by a copy of the trust document and contact with the trustee.	*I	*I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
UNEMPLOYMENT COMPENSATION BENEFITS (UCB)	Unearned – Benefits received from the Department of Labor (DOL) by unemployed individuals. Usually received weekly. Continue to count until notified by the A/R of termination. Use DOL Clearinghouse for verification of the amount and date of weekly benefits.	I	I
UNION FUNDS	Unearned – Refer to Strike Benefits in this chart.	I	I
UNIVERSITY YEAR FOR ACTION (UYA)	Unearned – payments received under a federal volunteer services program.	E	I
UTILITY PAYMENT (HUD SECTION 8/GRFA/FMHA)	Unearned - *Refer to Housing and Development (HUD) in this chart.	*	*
VACATION PAY	Earned – Any amount paid to employees for a regular scheduled period spent away from work or regular duty. It includes amounts paid even if the employee chooses not to take a vacation. Refer to Wages in this chart.	I	I
	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.	E	
	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.	I	
VENDOR PAYMENT	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. If the vendor payment is made with GA funds, refer to General Assistance Vendor Payments in this chart. For ABD, consider possibility of ISM. Refer to 2430 Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid.	E	
VETERANS ADMINISTRATION (VA) BENEFITS	Refer to 2418 VA Income for a description of the different types of VA income.		

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
VA PENSION	Unearned VA pensions are IBON and are not entitled to the $20 general exclusion. (Section 2505)	I (ABD) E (MAGI and Non MAGI FM)	I
VA COMPENSATION	Unearned VA compensation is not IBON. Compensation received by parents due to the service connected death of their child is IBON.	I (ABD) E (MAGI and Non MAGI FM)	I
VA EDUCATIONAL BENEFITS	Unearned	I (ABD) E (MAGI and Non MAGI FM)	E
Other VA Benefits Which are NOT Included As Income in the Eligibility Determination	Aid and Attendance	E	E
	Unusual Medical Expense (UME) reimbursement & Continuing Medical Expense (CME)	E	E
	Housebound Allowance	E	E
	Clothing Allowance	E	E
Augmented VA Benefits	Unearned *Refer to 2418 VA Income for specifics on counting Augmented VA income. Any portion of a VA check augmented for dependents is income to the dependent(s).	*I (ABD) E (MAGI and Non MAGI FM)	*I
Augmented VA Benefits To NH/CCSP A/Rs	Unearned *Refer to 2418 VA Income for specifics on counting Augmented VA income for LA-D A/Rs. Augmented VA benefits are treated differently than augmented RR benefits. The entire amount of an augmented RR check is income to the beneficiary.	*I (ABD) E (MAGI and Non MAGI FM)	*I
VA Recoupment	Repayment of VA benefits which are deducted from the VA check.	I Count the gross amount for eligibility determination FM-E	E Count the gross less recoupment
VA Lump Sum	Unearned *Any portion of a VA lump sum that is not VA Aid and Attendance, is not VA UME reimbursement or is not augmented is counted as unearned income for the month of receipt.	*I (ABD) E (MAGI and Non MAGI FM)	*I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
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
	The value of the payment does not exceed the value of the loss	E	E
	The value of the payment exceeds the value of the loss. Count the excess value as income in the month of receipt.	I	I
	The payment is a set monthly amount based on a court ruling. Count as income in the month of receipt.	I	I
VISTA VOLUNTEER PAYMENT	Earned – Income received by VISTA volunteers under Title I of the Domestic Volunteer Services Act. Included are payments from the Urban Crime Prevention Program	E	E
VOLUNTEER PAYMENT RSVP Foster Grandparent/ VISTA Urban Crime Prevention	Unearned – Title II of Domestic Volunteer Services Act of l973 Unearned – Payments from Title I. Exclude only if the A/R was receiving FS or AFDC at the time they joined Title I even if there is a break in participation.	E E	I I
WAGES (SALARIES) Children in Placement	Earned – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis. Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee's share of FICA when paid by the employer. Reference 2835 AFDC Relatedness Budgeting, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria.	I	I
WORKER'S COMPENSATION	Unearned – payments awarded to injured employees or to their survivors. Exclude any portion designated for medical, legal, or related expenses paid or deducted and not controlled by the A/R in connection with claim. Verify from the employer or from the source of the payment.	I (ABD) E (MAGI and Non MAGI FM)	I
WORKFORCE INVESTMENT ACT	Earned – Income received while working as part of a WIA program.	I	I
WORK STUDY PROGRAM (Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	E	N/A

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
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
YOUTH BUILD PROGRAM PAYMENTS	EARNED - Payments made through the Youth Build Program. *See WIA for treatment of this income.	I*	I*
YOUTH PROJECT PAYMENTS	Unearned – Payments made through projects developed to assist youth in acquiring work skills including the following: • Youth incentive entitlement pilot project • Youth community conservations and improvement projects • Youth employment *See WIA for treatment of this income.	I*	I*

Appendix R
Memos

MEMO Date	Title
8/21/14	RSDI Income of Tax Dependents for MAGI based Medicaid and PeachCare for Kids® determinations
2/20/15	Presumptive Eligibility Medicaid Federal Poverty Levels for 2015
7/9/15	Same Sex Marriage- How do we treat Income and Resources
3/11/16	Presumptive Eligibility Medicaid Federal Poverty Levels for 2016
2/20/17	Presumptive Eligibility Medicaid Federal Poverty Levels for 2017
2/19/18	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2018
9/11/18	Clarification to Declaration of Citizenship/Immigration Status
10/24/18	Dependent Tax Filing Threshold
2/20/19	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2019
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 Records
2/18/22	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2022
8/25/22	Ukrainian Nationals Policy
1/31/23	MAGI Medical Assistance Federal Poverty Levels for 2023
2/3/23	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2023
1/31/24	MAGI Medical Assistance Federal Poverty Levels for 2024
2/7/24	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2024

1/24/25	MAGI Medical Assistance Federal Poverty Levels for 2025
3/6/25	Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2025

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

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

February 20, 2015

MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2015

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

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

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

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

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

Budget Group	200% FPL
1	1962
2	2655
3	3349
4	4042
5	4735
6	5429
7	6122
8	6815
9	7509
10	8202
11	8895
12	9589

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

Please distribute to all State Office Staff, Supervisors, and members of the QP team that process the PE Pregnant Women Medicaid and /or the PE Women's Health Medicaid. If you have any questions or need additional information please contact Karen Y. Houston, Family Medicaid Program Consultant, at 404-657-7270.

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

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March 4, 2015

MEMORANDUM

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

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

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

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

Presumptive Eligibility (PE) Start Date

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

Women's Health Medicaid Panel Changes

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

Pregnant Women Panel Changes:

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

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

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

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July 9, 2015

MEMORANDUM

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

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

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

Question:

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

Response:

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

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

Please note we do not count resources in MAGI.

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

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

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Nathan Deal, Governor

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MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2016

DATE: March 11, 2016

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

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

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

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

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

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

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

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August 21, 2014

MEMORANDUM

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

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

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

BACKGROUND

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

PURPOSE

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

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

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

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

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

Note: RSDI does NOT count toward the unearned threshold.

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

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

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

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MEMORANDUM

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

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

DATE: July 7, 2016

RE: Clarification: 5% MAGI FPL deduction

DCH understands that the SUCCESS system is not currently programmed to correctly apply the 5% Modified Adjusted Gross Income (MAGI) Federal Poverty Level (FPL) deduction. Application of this deduction will be corrected with the implementation of the new Georgia Integrated Eligibility System, Georgia Gateway. This policy memo is to align policy correctly so that staff are trained appropriately in preparation for IES implementation.

This memo will provide clarification of the application of the 5% MAGI FPL deduction in the MAGI budget when determining eligibility for Medical Assistance benefits.

Section 2669-MAGI Budgeting in the Office of Family Independence Medicaid manual, states that a tax filer budget group's net taxable income is determined by deducting the following from the Budget Group's (BG) gross income:

- Cost of doing business for self-employed or farming/fishing individuals.
- Before-Tax deductions
- 1040 deductions
- MAGI 5% FPL deduction

The net taxable income is then compared against the FPL for the BG size to determine eligibility for Medical Assistance categories.

This memo clarifies that the MAGI 5% deduction is NOT applied at this point, but that Net Taxable income is determined by deducting the cost of doing business for self-employed or farming/fishing individuals; before-Tax deductions; or any 1040 deductions and THEN compared against the FPL for the BG size. If the BG's Net Taxable income puts the individuals requesting assistance over the income limit for MAGI Medical Assistance, then the 5% deduction is applied only if it will bring the BG under the income limit. If the MAGI household would NOT be eligible with the 5% deduction for MAGI Medicaid continue the Medical Assistance eligibility determination for the children with PeachCare for Kids® or Medically Needy Medicaid.

Procedures beginning on Section 2669-1 should be revised to read as in the enclosure.

Please update the Office of Family Independence Medicaid manual and notify field staff of the clarification of the 5% MAGI FPL deduction prior to pilot of Georgia Gateway. Please contact Yvonne Greene at 404-463-2135 or ygreene@dch.ga.gov or Jonathan Duttweiler at 404-651-9981 or jduttweiler@dch.ga.gov if you have additional questions.

Enclosure (2 pages)

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

PROCEDURES	Follow the steps below to determine eligibility for MAGI COAs.
Step 1	Deduct any pre-tax deductions to determine the Modified Adjusted Gross Income of the BG.
Step 2	For self employed individuals, deduct all allowable IRS deductions. Refer to Section 2415, Self-Employment.
Step 3	Select the appropriate income limit; either the Parent/Caretaker limit, or the appropriate Pregnant Women or Children Under 19 limit using the criteria below. Refer to Appendix A2, Financial Limits for Family Medicaid. • 220% of the FPL for pregnant women and infants born to Medicaid-eligible women **NOTE:** Infants born to Medicaid-eligible mothers are considered to have met the Newborn Medicaid income limit, regardless of the budget group's income at the time of delivery. • 205% of the FPL for children, birth through the month the child reaches age one for children who are ineligible for Newborn Medicaid. • 149% of the FPL for children age one through the month in which the child turns age six.133% of the FPL for children age six through the month in which the child turns age 19. • Parent/Caretaker with Child(ren) limit for Parent/Caretaker with Child(ren) COA.

Step 4 Compare the MAGI amount to the appropriate income limit for the BG size.

- If the net countable income is less than or equal to the appropriate income level, approve the AU members for Medical Assistance
- .
- If the net countable income exceeds the appropriate income level for the BG size, proceed to Step 5.

Step 5

Subtract from the net income the MAGI 5% deduction for the appropriate 100% FPL for the household size. Please refer to Appendix A-2 for the deduction amounts for each household size.

- If the net countable income is now less than or equal to the appropriate income level, approve the AU members for the appropriate Medical Assistance category.
- If the net countable income still exceeds the appropriate income level for the BG size, the AU members are ineligible for that category of Medical Assistance.
  If ineligible for Parent/Caretaker with Child(ren), continue the eligibility determination to Children Under 19 coverage. If ineligible for Children Under 19 coverage, review for eligibility under PeachCare for Kids® (PCK or Medically Needy Medicaid.

NOTE: Because the Children Under 19 income limits vary based on the age of the child, it is possible that a child(ren) may be eligible for Medical Assistance while another child(ren) in the same BG may be ineligible. Continue the eligibility determination as indicated above for an ineligible child(ren) in a budget group.

GEORGIA DEPARTMENT
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Nathan Deal, Governor

Frank W. Berry, Commissioner

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MEMORANDUM

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

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

RE: Presumptive Eligibility Medicaid Federal Poverty Levels for 2017

DATE: February 20, 2017

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

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

For each additional person over Budget Group size 12:
Add $50 (Parent/Caretaker with Children under 19)
Add $462 (133% FPL)
Add $517 (149% FPL)
Add $711 (205% FPL)
Add $763 (220% FPL)

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

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

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

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

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

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OF COMMUNITY HEALTH

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Frank W. Berry, Commissioner

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MEMORANDUM

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

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

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2018

DATE: February 19, 2018

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

Budget Group	5% Deduction	Parent/Caretaker with Children under age 19	133% Children 6-19	149% Children 1-5	205% Children 0-1	220% PGW
1	51	310	1,346	1,508	2,074	N/A
2	69	457	1,825	2,044	2,812	3,018
3	87	551	2,304	2,581	3,550	3,810
4	105	653	2,782	3,117	4,288	4,602
5	123	752	3,261	3,653	5,026	5,394
6	141	826	3,740	4,190	5,764	6,186
7	159	903	4,219	4,726	6,502	6,978
8	177	970	4,698	5,263	7,240	7,770
9	195	1,034	5,176	5,799	7,978	8,562
10	213	1,113	5,655	6,335	8,716	9,354
11	231	1,194	6,134	6,872	9,454	10,146
12	249	1,244	6,613	7,408	10,192	10,938

For each additional person over Budget Group size 12:
Add $50 (Parent/Caretaker with Children under 19)
Add $479 (133% FPL)
Add $537 (149% FPL)
Add $738 (205% FPL)
Add $792 (220% FPL)

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

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

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

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

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

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

MEMORANDUM

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

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

RE: Clarification to Declaration of Citizenship/Immigration Status

DATE: September 11, 2018

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

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

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

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

Please immediately inform staff of this clarification, update section 2215 of the Office of Family Independence Medicaid Manual, and submit Change Requests for any needed revisions in Georgia Gateway. If you have any questions or need additional information, contact Kunita Snead at 404-463-6234 or Kunita.snead@dch.ga.gov

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

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Frank W. Berry, Commissioner

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October 24, 2018

MEMORANDUM

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

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

RE: Dependent Tax Filing Threshold

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

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

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Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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MEMORANDUM

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

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

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2019

DATE: February 20, 2019

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

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

For each additional person over Budget Group size 12:
Add $19 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $490 (133% FPL)
Add $549 (149% FPL)
Add $755 (205% FPL)
Add $811 (220% FPL)

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

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

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

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

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

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Frank W. Berry, Commissioner

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September 24, 2019

MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager AW for AW
DCH Policy, Compliance & Operations

RE: Tax Cuts and Jobs Act of 2017/Bipartisan Budget Act of 2018

With the signing of the Tax Cuts and Jobs Act of 2017, PL 115-97, on December 22, 2017 and the Bipartisan Budget Act of 2018, PL 115-123 on February 9, 2018, the following changes are effective as of January 1, 2019.

Tax Cuts and Jobs Act of 2017, PL 115-97 changes to MAGI budgeting:

- Moving Expenses are no longer deducted for tax years 2018 through 2025, except for active duty service members of the Armed Forces
- Higher education tuition and fees for qualified education expenses are no longer deducted
- Temporary Census Bureau income is counted as income in MAGI budgets.
- Alimony is no longer considered as a deduction or income*
- Discharged Student Loan Debt is not included in income (and not counted in the MAGI-based income) of a student

Bipartisan Budget Act of 2018, PL 115-123:

- Lottery and Gambling lump sum winnings which are received in a single payment are counted as income (if less than $80,000 only count in month received, if $80,000 or more count equal amount over a period of time) **
- Notice provided to affected individuals must include, the date on which qualified winnings will no longer be counted

PL 115-97 applies changes to ABD resources, Achieving Better Life Experiences - ABLE accounts:

- Temporarily allows the designated beneficiary of an ABLE account to contribute additional monies, above the maximum annual limit, towards savings. The balance within a single ABLE account for an individual, including contributions and earnings, is an excluded resource.

*Divorces and separations finalized **before** January 1, 2019: **Include** as income and allow as a deduction. Divorces and separations finalized or modified **on or after** January 1, 2019: **Do not include** as income or a deduction.

**Winnings of $80,000 but less than $90,000 are counted as income over two months. For every additional $10,000 one month is added to the period. Total winnings are divided in equal installments. Winnings counted over multiple months, apply only to the individuals who received the winnings.

Please issue a numbered bulletin to expedite dissemination of this information to field staff and update Georgia Gateway and all applicable sections of the Office of Family Independence Medicaid Policy and Procedure manual to reflect this change. If you have any questions please contact Kunita Snead at Kunita.Snead@dch.ga.gov or 404-463-6234 or Anika Washington at awashington1@dch.ga.gov or 404-657-7262.

cc: Lynette Rhodes, Executive Director, Medical Assistance Plans
Brian Dowd, Deputy Executive Director, Policy, Compliance & Operations
Jonathan Duttweiler, Deputy Executive Director, Eligibility & Enrollment
Yvonne Greene, Policy Administration Director, Policy, Compliance & Operations
Mandy Corlee, RSM Medical Assistance Group, Interim Director
Stefanie Ashlaw, Director, PeachCare for Kids®
Melanee Payne, Medicaid Eligibility Quality Control, Manager
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Karen Salter, Myers and Stauffer

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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2020

DATE: February 19, 2020

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2020 Federal Poverty Level (FPL) income limits for Presumptive Eligibility (PE) Medical Assistance. The following FPL and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2020 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. These new income limits should be used for all PE determinations completed by Qualified Hospitals effective March 1, 2020.

Budget Group	5% Deduction	Parent/Caretaker with Children under age 19	133% Children 6-19	149% Children 1-5	205% Children 0-1	220% PGW
1	54	310	1,415	1,585	2,180	N/A
2	72	457	1,911	2,141	2,946	3,161
3	91	551	2,408	2,697	3,711	3,982
4	110	653	2,904	3,254	4,476	4,804
5	128	752	3,401	3,810	5,242	5,625
6	147	826	3,897	4,366	6,007	6,446
7	166	903	4,394	4,922	6,772	7,268
8	184	970	4,890	5,479	7,538	8,089
9	203	1,034	5,387	6,035	8,303	8,910
10	222	1,113	5,884	6,591	9,068	9,732
11	240	1,194	6,380	7,148	9,834	10,553
12	259	1,244	6,877	7,704	10,599	11,374

For each additional person over Budget Group size 12:
Add $19 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $497 (133% FPL)
Add $557 (149% FPL)
Add $766 (205% FPL)
Add $822 (220% FPL)

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

Budget Group	200% WHM
1	2,127
2	2,874
3	3,620
4	4,367
5	5,114
6	5,860
7	6,607
8	7,354
9	8,100
10	8,847
11	9,594
12	10,340

For each additional person over Budget Group size 12 add $747

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

cc: Lynette Rhodes, Executive Director, Medical Assistance Plans
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Jonathan Duttweiler, Deputy Executive Director, Eligibility and Enrollment Office
Catherine Ivey, Deputy Executive Director, Service Delivery and Administration
Yvonne Greene, Policy Administration Director
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Melanee Payne, Medicaid Eligibility Quality Control Manager
Stefanie Ashlaw, PeachCare for Kids® Director
Karen Salter, Myers and Stauffer

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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2021

DATE: February 19, 2021

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2021 Federal Poverty Level (FPL) income limits for Presumptive Eligibility (PE) Medical Assistance. The following FPL and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2021 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. These new income limits should be used for all PE determinations completed by Qualified Hospitals effective March 1, 2021.

Budget Group	5% Deduction	Parent/Caretaker with Children under age 19	133% Children 6-19	149% Children 1-5	205% Children 0-1	220% PGW
1	54	310	1,428	1,600	2,201	N/A
2	73	457	1,931	2,163	2,976	3,194
3	92	551	2,434	2,727	3,752	4,026
4	111	653	2,938	3,291	4,528	4,859
5	130	752	3,441	3,855	5,303	5,691
6	149	826	3,944	4,418	6,079	6,523
7	168	903	4,447	4,982	6,854	7,356
8	187	970	4,950	5,546	7,630	8,188
9	205	1,034	5,453	6,109	8,405	9,020
10	224	1,113	5,957	6,673	9,181	9,853
11	243	1,194	6,460	7,237	9,957	10,685
12	262	1,244	6,963	7,801	10,732	11,517

For each additional person over Budget Group size 12:
Add $19 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $504 (133% FPL)
Add $564 (149% FPL)
Add $776 (205% FPL)
Add $833 (220% FPL)

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

Budget Group	200% WHM
1	2,147
2	2,904
3	3,660
4	4,417
5	5,174
6	5,930
7	6,687
8	7,444
9	8,200
10	8,957
11	9,714
12	10,470

For each additional person over Budget Group size 12 add $757

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

cc: Lynnette Rhodes, Executive Director, Medical Assistance Plans
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Catherine Ivey, Deputy Executive Director, Service Delivery and Administration
Yvonne Greene, Director, Policy Administration
Stefanie Ashlaw, Director, PeachCare for Kids®
Melonie Wilson, Director, Regulatory Services and Compliance
Lynda Chapman, Attorney and Policy Manager
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Karen Salter, Myers and Stauffer

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Caylee Noggle, Commissioner

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Compact of Free Association (COFA) Migrants

DATE: July 16, 2021

The purpose of this memorandum is to provide new policy as it relates to Section 208 of the Consolidated Appropriations Act, 2021-COFA migrant Medicaid extension.

COFA Migrants Medicaid Extension

Effective December 27, 2020, section 208 of the Consolidated Appropriations Act, 2021 requires states and the District of Columbia (DC) to provide Medicaid coverage for individuals who are considered Compact of Free Association (COFA) migrants (also referred to as compact citizens).
The COFA Medicaid extension due to this legislation does not extend to PeachCare for Kids®.

COFA is an agreement between the United States and the three Pacific Islands sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, known as Freely Associated States.

Citizens of these Freely Associated States known as COFA migrants are to be considered "qualified non-citizens" and are not required to meet the 5-year waiting period required of other non-citizen immigrants.

DFCS must collect information regarding eligible immigration status on the Medical Assistance application and verify the immigration status of applicants through the SAVE program. (1137(d) of the Social Security Act; 42 CFR 435.406)

If unable to promptly verify citizenship or immigration status, Medical Assistance should be provided during a 90-day reasonable opportunity period (ROP) to applicants who attest to citizenship or have an eligible immigration status and meet all other eligibility requirements for Medical Assistance.

Until updates are made by the Federal Data Services Hub (FDSH) and the Federally Facilitated Marketplace (FFM), immigration status for COFA migrants may not be accurately provided and other established pathways should be used to verify the applicants' immigration status.

Please issue a numbered bulletin to expedite the dissemination of this information to field staff. Update Georgia Gateway and all applicable sections of the Office of Family Independence Medicaid Policy and Procedure manual to reflect this change. If you have any questions or need additional information, please contact Teresa Fair at 470-727-7207 or Teresa.Fair@dch.ga.gov.

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

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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Retention of Presumptive Eligibility Application Packets

DATE: February 14, 2022

The purpose of this memorandum is to provide information regarding retention of Presumptive Eligibility (PE) application packets. Effective February 14, 2022, Department of Community Health (DCH) request all PE application packets completed by Qualified Hospitals (QH) be retained for a minimum of six months from the date of application. The storage of these PE application packets can be retained electronically or physically based on the hospital's policy/procedure. The electronic version of the PE application packets must be legible.

Please distribute to all Hospital Staff, Supervisors, and members of the QH team that process PE Parent/Caretaker with Children under age 19, PE Children under age 19, PE Pregnant Women and/or PE Women's Health Medical Assistance determinations. If you have any questions or need additional information, please contact Kunita Snead at 404-463-6234 or Kunita.snead@dch.ga.gov or Teresa Fair at 404-651-9978 or Teresa.fair@dch.ga.gov.

cc: Lynnette Rhodes, Executive Director, Medical Assistance Plans
Brian Dowd, Deputy Executive Director, Policy, Compliance and Operations Office
Catherine Ivey, Deputy Executive Director, Service Delivery and Administration
Tara Dickerson, Deputy General Counsel
Malcolm Wells, Director, Medicaid Legal Services
Karen Salter, Myers and Stauffer

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MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2022

DATE: February 18, 2022

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2022 Federal Poverty Level (FPL) income limits for Presumptive Eligibility (PE) Medical Assistance. The following FPL and income increases are based on the Center for Medicare and Medicaid Services (CMS) 2022 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and the District of Columbia. These new income limits should be used for all PE determinations completed by Qualified Hospitals effective March 1, 2022.

Budget Group	5% Deduction	Parent/Caretaker with Children under age 19	133% Children 6-19	149% Children 1-5	205% Children 0-1	220% PGW
1	57	310	1,507	1,688	2,322	N/A
2	77	457	2,030	2,274	3,128	3,357
3	96	551	2,553	2,860	3,935	4,223
4	116	653	3,076	3,446	4,741	5,088
5	136	752	3,599	4,032	5,547	5,953
6	155	826	4,122	4,618	6,354	6,819
7	175	903	4,646	5,204	7,160	7,684
8	195	970	5,169	5,790	7,966	8,549
9	214	1,034	5,692	6,376	8,773	9,415
10	234	1,113	6,215	6,963	9,579	10,280
11	254	1,194	6,738	7,549	10,385	11,145
12	273	1,244	7,261	8,135	11,192	12,011

For each additional person over Budget Group size 12:
Add $20 (5% Deduction)
Add $50 (Parent/Caretaker with Children under 19)
Add $524 (133% FPL)
Add $587 (149% FPL)
Add $807 (205% FPL)
Add $866 (220% FPL)

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

Budget Group	200% WHM
1	2,265
2	3,052
3	3,839
4	4,625
5	5,412
6	6,199
7	6,985
8	7,772
9	8,559
10	9,345
11	10,132
12	10,919

For each additional person over Budget Group size 12 add $787

Please distribute to all Hospital Staff, Supervisors and members of the QH team that process PE Parent/Caretaker with Children under age 19, PE Children under age 19, PE Pregnant Women and/or PE Women's Health Medical Assistance determinations. If you have any questions or need additional information, please contact Kunita Snead at 404-463-6234 or Kunita.snead@dch.ga.gov or Teresa Fair at 470-727-7207 or Teresa.fair@dch.ga.gov.

cc: Lynnette Rhodes, Executive Director, Medical Assistance Plan
Erian 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®
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2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

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

FROM: Anika Washington, Eligibility Policy Manager
DCH Policy, Compliance and Operations Office

RE: Ukrainian Nationals

DATE: August 25, 2022

The purpose of this memorandum is to provide information as it relates to Medicaid and Peachcare for Kids ® eligibility for Ukrainian Nationals.

The U.S. Department of Homeland Security (DHS) is providing support and humanitarian relief to Ukrainians who have been displaced. Most Ukrainian nationals arriving in the United States are eligible for health coverage. Certain Ukrainian nationals are eligible for health coverage through Medicaid, Peachcare for Kids®, the Health Insurance Marketplace®, or Refugee Medical Assistance (RMA).

Ukrainian nationals who enter the United States as parolees on or between February 24, 2022, and September 30, 2023, are eligible for Medicaid or Peachcare for Kids ® to the same extent as refugees, without a five-year waiting period, if they meet all other eligibility requirements. These Ukrainian parolees are considered "qualified non-citizens" for the purposes of Medicaid and Peachcare for Kid® eligibility since they are eligible for the same benefits as refugees.

Ukrainian nationals who are paroled into the U.S. after September 30, 2023 and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and PCK to the same extent as refugees.

Ukrainians granted Temporary Protected Status (TPS), and Ukrainians who have pending applications for TPS and who have been granted employment authorization are not considered "qualified non-citizens" for purposes of Medicaid and Peachcare for Kids® eligibility, and thus are not eligible for Medicaid or Peachcare for Kids®.

Ukrainian non-citizens who do not qualify for full Medicaid benefits based on their immigration status may be eligible for Emergency Medical Assistance (EMA), if they meet all other eligibility requirements.

Please issue a numbered bulletin to expedite the dissemination of this information to field staff. Update Georgia Gateway and all applicable sections of the Office of Family Independence Medicaid Policy and Procedure manual to reflect this change. If you have any questions or need additional information, please contact Anika Washington at awashington1@dch.ga.gov.

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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Caylee Noggle, Commissioner

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

MEMORANDUM

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

FROM: Anika Washington, Eligibility Policy Manager
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)

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Russel Carlson, Commissioner

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MEMORANDUM

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

FROM: Anika Washington, Interim Policy Administration Director
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)

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.

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

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

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M E M O R A N D U M

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

FROM: Stacy Merriweather, Eligibility Policy Manager
DCH Policy, Compliance, and Operations Office

RE: **Presumptive Eligibility Medical Assistance Federal Poverty Levels for 2025**

DATE: March 6, 2025

The purpose of this memorandum is to inform Qualified Hospitals (QH) of the 2025 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) 2025 Federal Poverty Level Guidelines at 100% for the 48 contiguous States and District of Columbia. These new income limits should be used for all PE determinations completed by the Department of Public Health, effective March 1, 2025.

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	66	310	1,735	1,944	2,675	N/A
2	89	457	2,344	2,626	3,614	3,878
3	111	551	2,952	3,307	4,551	4,884
4	134	653	3,563	3,991	5,491	5,893
5	157	752	4,172	4,674	6,430	6,901
6	180	826	4,781	5,356	7,369	7,909
7	203	903	5,391	6,040	8,310	8,918
8	226	970	6,000	6,722	9,249	9,926
9	249	1,034	6,610	7,405	10,188	10,934
10	272	1,113	7,219	8,087	11,127	11,941
11	295	1,194	7,828	8,770	12,066	12,949
12	318	1,244	8,437	9,452	13,005	13,956

For each additional person over Budget Group size 12:

Add $23.00 (5% Deduction)
Add $150.00 (Parent/Caretaker with Children under 19)
Add $610.00 (133% FPL)
Add $683.00 (149% FPL)
Add $939.00 (205% FPL)
Add $1,088.00 (220% FPL)

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

Budget Group	200% WHM
1	2,610
2	3,526
3	4,440
4	5,358
5	6,274
6	7,190
7	8,108
8	9,024
9	9,940
10	10,856
11	11,772
12	12,688

For each additional person over Budget Group size 12:

Add $916.00 (200% FPL)

Please distribute to all State Office Staff, Supervisors, and members of the QH team that process PE Parent/Caretaker with Children under age 19, PE Children under age 19, Pregnant Women and/or PE Women's Health Medical Assistance determinations. If you have any questions or need additional information, please contact Jacqueline Huggins at 470-433-8492 or Jacqueline.Huggins3@dch.ga.gov.

Cc: Stuart Portman, Executive Director, Medical Assistance Plans
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, PeachCare for Kids® Director
Waverly Wesson, Manager 2, Information Technology

Appendix S
Planning for Healthy Babies Postcards





Helping You Grow Your Family On Your Terms.

HOW DO I APPLY?

You can apply online at: gateway.ga.gov

If you are unable to apply online, you can pick up a physical application at your local:

- Public Health Department
- Division of Family and Children Services (DFCS) Office

Completed physical applications and required documentation should be faxed (912-632-0389) or mailed to:

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



WHERE CAN I GO FOR MORE INFORMATION?

1-877-427-3224

https://medicaid.georgia.gov/planning-healthy-babies

PLANNING FOR HEALTHY BABIES (P4HB)



DO YOU NEED ACCESS TO FREE BIRTH CONTROL?

WHAT IS PLANNING FOR HEALTHY BABIES (P4HB)?

Planning for Healthy Babies provides no-cost family planning services to eligible Georgia residents. The goal of P4HB is to help women be healthy and plan ahead in order to have healthy babies when they are ready to start their families! P4HB members get family planning, interpregnancy care and/or Resource Mother outreach services.

WHAT IS COVERED?

- Family planning initial or annual exams
- Follow up family planning visits
- Pap smears and pelvic exams
- Birth control and multivitamins with folic acid
- Patient education and counseling
- Select immunizations for participants aged 18-20
- Counseling and referrals to social services

WHAT ARE THE ELIGIBILITY REQUIREMENTS?

- Uninsured individuals ages 18-44
- Georgia state resident
- Family income at or below 211 percent of the Federal poverty level
- Ability to become pregnant
- Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP)

PLANNING FOR HEALTHY BABIES (P4HB)



HOW DO I APPLY?

You can apply online at: gateway.ga.gov

If you are unable to apply online, you can pick up a physical application at your local:

- Public Health Department
- Division of Family and Children Services (DFCS) Office

Completed physical applications and required documentation should be faxed (912-632-0389) or mailed to:

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



WHERE CAN I GO FOR MORE INFORMATION?

1-877-427-3224

https://medicaid.georgia.gov/planning-healthy-babies

PLANNING FOR HEALTHY BABIES (P4HB)

Appendix T
How to Order Understanding Medical Assistance booklets

Web Access

- Go To:

https://www.mmis.georgia.gov

Member Information tab and then to the Member Notification tab.

Georgia Department of Community Health

Member Information Tab:



Web Print

A. 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%20boo klet%20%20final_e%2020171003130824.pdf

OR

www.dch.georgia.gov

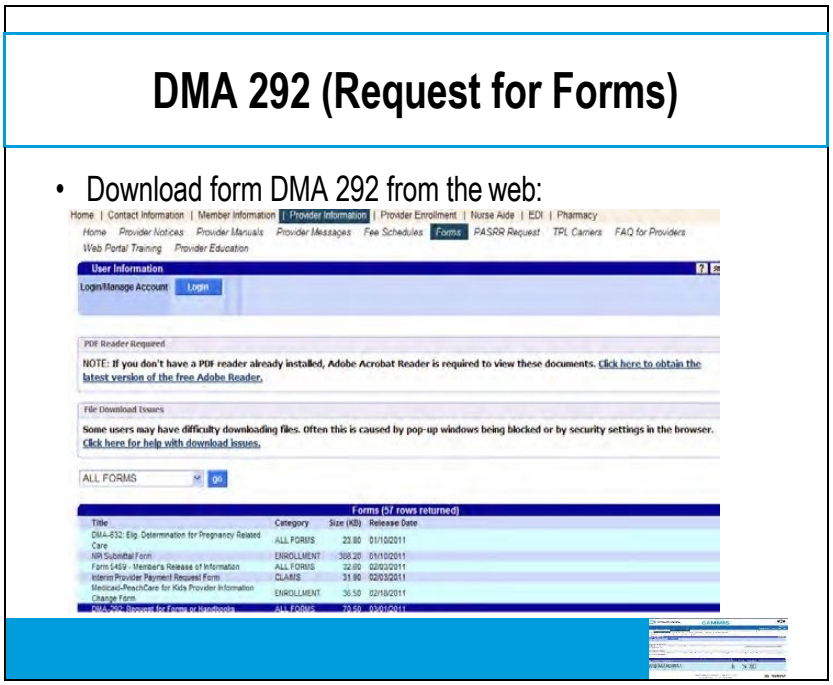
i. Select Medicaid

ii. Select Medicaid Publications from the left column

iii. Under related Files Select “Medical Assistance Plans booklet”



B. Download form DMA 292 from the web:





i. Mail form DMA 292 to:

Gainwell Technologies P. O. box 105209 Tucker, GA 30085-5209

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