Table of Contents

State/Territory Name: Georgia

State Plan Amendment (SPA) #: 13-0021-MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 10, 2014

Dr. Jerry Dubberly, Chief
Medical Assistance Plans
Georgia Department of Community Health
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303

RE: S94 – Eligibility Process State Plan Amendment (SPA), GA 13-0021-MM2

Dear Dr. Dubberly:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of Georgia's state plan amendment (SPA) transmittal GA-13-0021-MM2, which was submitted to CMS on November 18, 2013. Our review of this submission included a review of the online alternative single streamlined application developed by the state.

Until December 31, 2014, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

Necessary Changes	**Date by which changes will be completed:**
Reference to 6 months in Former Foster Care questions will be removed in the next revision.	July 1, 2014
Questions regarding access to employer-sponsored coverage, beyond what is needed for Medicaid and CHIP, will only be asked of applicants above the income limit for Medicaid and CHIP. The information collected regarding access to employer-sponsored coverage will be updated in accordance with the model CMS application.	December 31, 2014

Please submit the revised alternative single streamline online application to CMS for review no later than December 1, 2014 to ensure approval by December 31, 2014. We continue to be available to provide technical assistance.

If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any additional questions or require any further assistance, please contact Tandra Hodges at (404) 562-7409 or at Tandra.Hodges@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 10, 2014

Dr. Jerry Dubberly, Chief
Medical Assistance Plans
Georgia Department of Community Health
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303

RE: S94 – Eligibility Process State Plan Amendment (SPA), GA-13-0021-MM2

Dear Dr. Dubberly:

Enclosed is an approved copy of Georgia's state plan amendment (SPA) GA-13-0021-MM2, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 18, 2013. SPA GA-13-0021-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Georgia's Medicaid state plan in accordance with the Affordable Care Act. This SPA was approved on February 7, 2014. The effective date of this SPA is October 1, 2013.

The approval of SPA GA-13-0021-MM2 includes full approval of your state's alternative multi-benefit paper application. The state is using an interim alternative single streamlined online application and by December 31, 2014 will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of Georgia's approved state plan:

- S94, pages S94-1 and S94-2
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application

In addition, enclosed is a summary of state plan pages which are superseded by SPA GA-13-0021-MM2, which should also be incorporated into a separate section in the front of the state plan.

- Superseding Pages of State Plan Material, GA-13-0021-MM2

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Tandra Hodges at (404) 562-7409 and Tandra.Hodges@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

Medicaid State Plan Eligibility: Summary Page (CMS 179)

- State/Territory name:

  Georgia

- **Transmittal Number:**

  Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

  GA 13-021

- **Proposed Effective Date**

  01/01/2014 (mm/dd/yyyy)

- **Federal Statute/Regulation Citation**

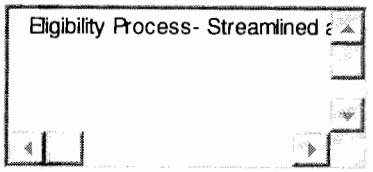
  42 C.F.R. §

- **Federal Budget Impact**

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

- **Subject of Amendment**

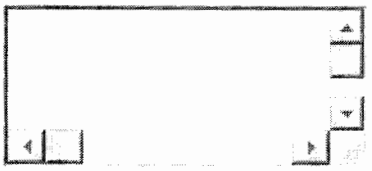
Character Count: out of 2000



- **Governor's Office Review**

- ○ Governor's office reported no comment
- ○ Comments of Governor's office received

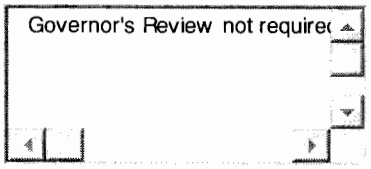
  Describe:



- ○ No reply received within 45 days of submittal
- ○ Other, as specified

  Describe:

Character Count: out of 2000



- **Signature of State Agency Official**
- ○ Submitted By:

  Therese Brisco

- ○ Last Revision Date:

  Nov 18, 2013

- ○ Submit Date:

Nov 18, 2013

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0021-MM2	**STATE:** Georgia
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2.1 (d) TN 91-30, Effective Date 07/01/91, Approved 10/22/92 Section 2.1 (a) TN 91-31, Effective Date 10/1/91, Approved 12/18/91

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☒ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☐ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	COMPASS	COMPASS is a quick and easy way for people in Georgia to apply for Medicaid, TANF, SNAP and get answers to questions about health and human services	X
+	Fax	Individuals may submit applications by fax.	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

Medicaid Eligibility

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours 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.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER:	**STATE:**
GA-13-0021-MM2	Georgia

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

Georgia Department of Human Services

Application for Benefits



If you need help filling out this application, ask us or call 1-877-423-4746. If you have a hearing impairment, call GA Relay at 1-800-255-0135. Our services are free.

What Services Do We Offer at the Division of Family and Children Services (DFCS)?

DFCS offers the following services:

Food Assistance

Food Stamps are benefits that you can use to buy food at any store that has the EBT/*Quest* sign. We will subtract the price of your food purchase from your Food Stamp account.

Cash Assistance/Employment Support Services

Temporary Assistance for Needy Families (TANF) provides cash assistance to families with dependent children for a limited time. Parents or caretakers who are included in the grant are required to participate in a work program.
Cash Assistance program also provides financial assistance to refugee households who are not eligible for the TANF program.

Medical Assistance

Medicaid, for those who are eligible, may help pay medical bills, doctor's visits, and Medicare premiums.

Community Outreach Services

For more information about Community Outreach Services, please visit our website at: http://www.dfcs.dhr.georgia.gov or call 1-877-423-4746.

How Do I Apply for Benefits?

Step 1. Fill out the application.

Read the questions carefully and give accurate information. Sign and date the application.

Step 2. Turn in the application. You will need to tear off pages 1 and 2 and keep it for yourself.

Mail, fax, or bring in pages 3-6 of this application to your local Division of family & Children Services (DFCS) office. If you or the person for whom you are applying is eligible for benefits, Food Stamps or TANF benefits will be provided from the date that we receive the application with your name, address, and signature on it.

If you apply for Food Stamps, and/or Medicaid you can file an application for benefits with only your name, address and signature. However, it may help us to process your application quicker if you complete the entire form.

Step 3. Talk with us.

You may need to complete an interview with a case manager. If so, we will give you an appointment. This interview can be completed by phone.

Frequently Asked Questions

How long does it take to get benefits?

Food Stamps:	up to 30 days
TANF:	up to 45 days
Medicaid:	10 to 60 days

You may be able to get Food Stamps within 7 days if you qualify. See page 4.

How much will I get?

Your income, resources, and family size determine benefit amounts. We will be able to give you specific information once we determine your eligibility.

How will I get my benefits?

For Food Stamps and TANF, you will get an Electronic Benefit Transfer (EBT) card to access your benefits. For Medicaid, you will receive a Medicaid card for each eligible member.

What information will I need to provide?

It is a good idea to provide the following:

- Proof of identity for the applicant if applying for Food Stamps and/or TANF. Proof of identity for everyone requesting Medicaid if applying for Medicaid. Ex: An identification card (ID) or driver's license (DL)
- Proof of US citizenship/qualified immigrant status for everyone requesting benefits
- Social Security numbers of everyone requesting assistance
- Proof of income *for example*, pay stubs, child support payments, and income award letters
- Proof of expenses like child care receipts, medical bills, medical transportation costs, and child support payments

You will be given time to return any information to our office. If you need help getting this information, please tell us.

How do we use the applicant's personal information?

You only have to provide Social Security Numbers (SSN) and citizenship or immigration status for persons who want to apply for benefits. This information will be used to check the income and eligibility verification system (IEVS). We will also match your information against other Federal, state and local agencies to verify your income and eligibility. If a household member does not want to give us information about their SSN, citizenship, or immigration status, other household members may still receive benefits.

Can someone else apply for me?

Yes, for Food Stamps and Medicaid, you may ask someone to apply for you.
For TANF, anyone can apply but the parent or caretaker must be interviewed.

"In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the **Food and Nutrition Act of 2008** and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs."

To file a complaint of discrimination, you may contact USDA or HHS.

Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9411 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY).

Write HHS, Director, Office of Civil Rights, Room 509-F, 200 Independence Avenue, S.W., Washington, D.C., 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY).

USDA and HHS are equal opportunity providers and employers

You may also file a complaint of Discrimination by contacting the DFCS Civil Rights Program, Two Peachtree Street, N.W., Suite 19-248, Atlanta, Georgia 30303 or call (404) 657-3735 or fax (404) 463-3978.

Under the Department of Community Health (DCH) policy, Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report Medicaid eligibility or provider discrimination, call the Georgia Department of Community Health's Office of Program Integrity (local 404-463-7590) (toll free) 800-533-0686.

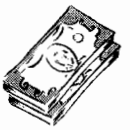
What Do the Words Used in this Application Mean?

This chart explains the words we have used in this application.

Caretaker	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
Grantee Relative	A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.
Disqualified	The action taken to remove an individual from a Food Stamp or TANF case because they did not tell the truth and received benefits that they should not have received.
Electronic Benefit Transfer (EBT)	The system used in Georgia to pay benefits to individuals who are eligible for Food Stamps or TANF. Individuals receiving assistance are issued an EBT debit card, which is used to withdraw cash benefits and to access their food stamp accounts.
Household Members	Individuals who live in your home.
Income	Payments such as wages, salaries, commissions, bonuses, worker's compensation, disability, pension, retirement benefits, interest, child support or any other form of money received
Migrant Farm Workers	Individuals who are seasonal farm workers and move from one home base to another to work or look for farm work
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance
Seasonal Farm Workers	Individuals who work at certain times of the year planting, picking or packing produce. They are hired on a temporary basis when a job requires more workers than the farm employs on a regular basis
Trafficking	Selling or trading Food Stamp benefits for profit
Qualified Alien/Immigrant	A *qualified alien/immigrant* is a person who is legally residing in the U.S. who falls within one of the following categories: a person lawfully admitted for permanent residence (LPR) under the Immigration and Nationality Act (INA); *Amerasian* immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988; a person who is granted asylum under section 208 of the INA; *Refugees*, admitted under section 207 of the INA; A person *paroled* into the US under section 212(d)(5) of the INA for at least one year; A person whose *deportation* is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997 , or section 241(b)(3) of the INA, as amended; a person who is granted *conditional entry* under section 203(a)(7) of the INA as in effect prior to April 1, 1980; *Cuban or Haitian* immigrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980; *victims of human trafficking* under section 107(b)(1) of the Trafficking Victims Protection Act of 2000; *battered immigrants* who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended; *Afghan or Iraqi* immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions); *American Indians* born in Canada living in the U.S. under section 289 of the INA or non-citizens of federally-recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and *Hmong or Highland Laotian tribal members* that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 – 5/07/1975).
Applicant	An individual who chooses to apply for or to receive public assistance/benefits
Non-applicant	An Individual who chooses NOT to apply for or to receive public assistance/benefits; non-applicants are not required to provide an SSN, citizenship or immigration status.
Assistance Unit	An assistance unit includes *eligible* individuals who live together and receive public assistance/benefits together.

Georgia Department of Human Services

Application for Benefits


What Am I Applying For? Check all that apply:

- ❑ **Food Stamps**
  The Food Stamp program helps meet the food and nutritional needs of eligible households.

- ❑ **Temporary Assistance for Needy Families (TANF)**
  Temporary Assistance for Needy Families (TANF) provides temporary monthly cash payments, single cash payments, or other support services, to strengthen eligible families with children. If you are the child's parent, or the caretaker who would like to be included in the grant, we will require you to participate in a work program.

- ❑ **Refugee Cash Assistance**
  The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.

- ❑ **Medicaid**
  Medicaid offers medical coverage to elderly, blind or disabled adults, pregnant women, children, and families. When you apply, we will look at all Medicaid programs and decide which ones you may be eligible to receive.

Tell Us About The Applicant

Does the applicant or person applying on behalf of the applicant need assistance when communicating with us? If so check all that apply.

( ) TTY ( ) Braille ( ) Large Print ( ) E-mail ( ) Video Relay) ( ) Sign Language Interpreter _____

( ) Foreign Language Interpreter (specify language) _____ ( ) Other _____

Please fill out the chart below about the applicant.

First Name	Middle Initial	Last Name	Suffix
Street Address Where You Live		Apt	
City	State	Zip Code	
Mailing Address (if different)			
City	State	Zip Code	
Home Telephone Number	Other Contact Number	E-Mail address	
Signature	Date		
Witness Signature if signed by 'X'	Date		
For Office Use Only	Date Received By The County		

Do I Qualify to Get Food Stamps Faster?

Answer these questions about the applicant and all household members to see if you can get Food Stamps within 7 days.

1. Are you or any household member a migrant or seasonal farm worker? ❑ Yes ❑ No

2. Total **Gross earned income** that will be received for this month: $_____
   Employer Name _____
   Employment Begin Date _____ Employment End Date_____
   Rate of Pay _____ Hours Worked Weekly _____ wk/bi-wk/semi-mo/mo (circle one)

3. Total **Gross unearned income** that will be received for this month: $_____
   Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)
   Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)

4. Total earned and unearned income for this month: $_____

5. How much money do you and all household members have in cash or in the bank? $ _____

6. How much do you and all household members pay for rent or mortgage? $ _____

7. How much do you and all household members pay for electric, water, gas, etc.? $ _____

Can I Choose Someone to Apply for Food Stamps or Medicaid for me?

Complete this section only if you want someone to fill out your application, and/or complete your interview, and/or use your EBT card to buy food when you cannot go to the store. You can choose more than one person.

Name: _____ Phone: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Name: _____ Phone: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____

For Medicaid, do you want this individual to have a copy of your Medicaid card? ❑ Yes ❑ No

Tell Us about the Applicant and All Household Members

Please fill out the chart below about the applicant and all household members. The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request your and your household members social security number(s).If anyone in your household does not want to give us

information about his or her citizenship, immigration status, or social security numbers, then that person can be designated as a non-applicant. This means that the person will not be considered an applicant and will not be eligible for benefits. However, other household members may still be able to receive benefits, if they are otherwise eligible. If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their SSN. You will still need to tell us about your income and resources to determine the eligibility and benefit level of the household. Individuals will not be reported to the United States Citizenship and Immigration Services if they do not give us their citizenship or immigration status.

NAME First Middle Initial Last	Relation -ship to You	Is this person applying for benefits? (Y/N)	Birth Date Format (- -/ - -/ - -)	Social Security Number **(Applicants Only)**	Sex (M/F)	Hispanic/ Latino? **(Optional)** (Y/N)	Race Code **(Optional)** (See codes Below)	Are you a U.S citizen, qualified alien/immigrant or Hmong/Highland Laotian Immigrant? **(Applicants only)** (Y/N)
	SELF							

Race Codes (Choose all that apply):
AI – American Indian/Alaska Native **AS** – Asian **BL** – Black/African American
HP – Native Hawaiian/Pacific Islander **WH** – White

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

Tell Us More about the Applicant and All Household Members

We need more information about the applicant and all household members in order to decide who is eligible for benefits. Please answer only the questions about the benefits you want to receive on the page below.

1. Has anyone received any benefits in another county or state? ❑ Yes ❑ No

   Who: _____
   What: _____
   Where: _____
   When: _____

2. Did anyone in your house hold voluntarily quit a job or voluntarily reduce his/her work hours below 30 hours per week since the last application or review? ❑ Yes ❑ No

   If yes, who quit? _____
   Why did he/she quit? _____

3. Is anyone pregnant? For TANF, please provide proof of pregnancy if available. ❑ Yes ❑ No

(This question does not apply to Food Stamp only applicants)

Who: _____

Due Date: _____

4. Is anyone disqualified from the Food Stamp or TANF Program? ❑ Yes ❑ No

a. Who: _____

b. Where: _____

5. Is anyone trying to avoid prosecution or jail for a felony? (For TANF and FS only) ❑ Yes ❑ No

Who: _____

6. Is anyone violating conditions of probation or parole? (For TANF and FS only) ❑ Yes ❑ No

Who: _____

7. Has anyone been convicted of a drug felony (For TANF and FS only) or violent felony (For TANF only)? ❑ Yes ❑ No

Who: _____

When: _____

I have read and completed everything on this form that applies to the applicant and the applicant's household. I certify, under penalty of perjury, all the information that I provided is true and complete as far as I know. I understand I can be punished by law if I do not tell the complete truth.

_____ _____

Applicant's Signature Date

_____ _____

Authorized Representative's Signature Date

_____ _____

Case Manager's Name and Signature Date

Georgia Department of Human Services

Health Coverage Addendum

Please answer the following questions if you are applying for Health Coverage
(Please complete all three pages of this form)

1. If you are an adult applying for Health Coverage for your dependent child(ren), do you want to receive Health Coverage for yourself? ❑ Yes ❑ No
2. Is anyone in the household pregnant? ❑ Yes ❑ No If **yes**, how many babies are expected during this pregnancy? _____
3. Is anyone applying for health coverage blind or disabled? ❑ Yes ❑ No
   If yes, please list_____
4. Does anyone have other health insurance that covers anyone in your household? ❑ Yes ❑ No
5. If you answered yes to question 5 above, please complete the following information:

Name of Policy holder	Health Insurance Company Name, Address and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical)	Name of Persons Covered	Effective Date	Policy Number

6. 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 Attachment A. Is this a state employee benefit plan? ❑ Yes ❑ No
7. Have you or anyone listed on this application lost any health coverage in the last 2 months?
   ❑ Yes If **yes**, why was it lost? _____
   ❑ No
8. Was anyone in your household in Foster Care at age 18? ❑ Yes ❑ No
9. Does anyone in the household have any unpaid medical bills from the last 3 months? ❑ Yes ❑ No
10. Is anyone in your household American or Alaska Native? ❑ Yes ❑ No
    If Yes, complete Attachment B.

If you are applying for Aged, Blind or Disabled Medicaid please answer questions 11-16 and complete the Resources section. Otherwise, skip to the tax filer questions on page 3.

11. Are you or your spouse currently covered by Medicare?
    ❑ Yes ❑ No If Yes please list, _____
12. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?
    ❑ Yes ❑ No If yes, date of SSI application: _____
13. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?
    ❑ Yes ❑ No
14. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
    ❑ Yes ❑ No

15. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?
❑ Yes ❑ No

16. Are you applying for Medicaid to help pay for community based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?
❑ Yes ❑ No

Resources: Check all resources (assets) owned by you, your spouse, your dependents or jointly owned with someone else. Attach additional pages if necessary.

Checking Accounts	❑ Yes ❑ No	Funeral Plans/Prepaid Burial Item	❑ Yes ❑ No
Savings Accounts	❑ Yes ❑ No	Burial Plots or Contracts	❑ Yes ❑ No
Government Bonds	❑ Yes ❑ No	Stocks and Bonds	❑ Yes ❑ No
Trust Funds	❑ Yes ❑ No	Other (IRA, CD, etc.)	❑ Yes ❑ No
Real Property/Homeplace Property			❑ Yes ❑ No
Have you or your spouse given away any assets for less than its value?			❑ Yes ❑ No

If you answered yes to any of these questions, please describe below.

Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.

Does anyone in the household own a vehicle? If so, please describe below. ❑ Yes ❑ No

Vehicle Make	Model	Year	Amount Owed

Do you or your spouse have a life insurance policy? ❑ Yes ❑ No
If yes, please complete the following information.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ❑ Yes ❑ No
If **yes**, who? (list each person who plans to file)_____

2. Will any of the tax filers listed file jointly with a spouse? ❑ Yes ❑ No If **yes**, please list spouse's name:_____

3. Will any of the tax filers claim any dependents on their tax return? ❑ Yes ❑ No If **yes**, please list name(s) of dependents:_____

4. Will anyone be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If **yes**, please list the name of the tax filer and the dependent:_(Filer)_____
(Dependent)_____
How is the tax dependent related to the tax filer? _____

Income and Earnings: List all types of earnings and income that your household receives. List the income amount before deductions such as taxes, insurance or Medicare premiums , health insurance, dental, and vision premiums or Spending accounts are taken out.

Income Type	Gross amount	How often? (weekly, every 2 weeks, monthly, etc.)	Name of Person Receiving
Wages/Salary			
Current Employer:			
Wages/Salary			
Current Employer:			
Self Employment			
Unemployment Benefits			
Social Security Income			
SSI			
Worker's Compensation			
Pension/Retirement Benefits			
Veterans Benefits			
Child Support			
Alimony			
Contributions			
Other Income (please specify)			

Does anyone expect any change in monthly income? ❑ Yes ❑ No
If yes, please list who expects the change, the type of income that is changing, and the date it is expected to change below.

_____

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

❑ Alimony $_____ How often? _____ ❑ Other Deductions $_____ How often?_____

❑ Student loan interest $_____ How often?_____

Assignment of Rights of Payment for Medical Support and Other Medical Care:
(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his/her eligibility for Medicaid.) As a condition of my eligibility, I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits). I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days. I agree to give the State the right to require an absent parent to provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do **not** cooperate, I understand I may lose my Medicaid benefits, and only my child(ren) will receive benefits unless good cause is established.

I certify, under penalty of perjury, that all the information listed is truthful to the best of my knowledge.

_____ _____
Signature Date

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

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

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

CHILDREN SEEKING BENEFITS

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

I, _____, declare the child/children is/are a U.S. Citizens or a Qualified Immigrant.
(PRINT NAME)
I attest to the identity of the child/children listed above, and certify under penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (PARENT/GUARDIAN) (DATE)

ADULT(S) SEEKING BENEFITS

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

I, _____ , declare I am a U.S. Citizen or a Qualified Immigrant. I certify under
(PRINT NAME)
penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (DATE)