Appendix F Forms Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Forms Overview		
	Effective Date:	N/A		
	Chapter:	Appendix F	**Policy Number:**	Appendix F
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-41

Policy Statement

Only State Office approved forms may be used.

Basic Considerations

Medicaid Eligibility Specialists must **not** require more of applicant/recipients than placed by federal and state regulations and policies.

System generated notices and forms issued by the State Medicaid Unit and other State agencies are listed in Appendix F.

Use of State Office approved forms safeguards the following:

- Accessibility of the Medicaid Program
- Minimization of barriers to applying for benefits
- Simplification of the renewal process
- Compliance with the Office of Civil Rights
- Timely and Adequate notice of eligibility decisions

Forms Issued by Other Policy Units

Information obtained via forms issued by other policy units may be used in making Medicaid eligibility decisions, but should not be routinely used by MES'.

Forms issued by other policy units that **will** be used by MES' on a regular basis include the following:

- Form 138, Notice of Requirement to Cooperate with CSS
- Form 256, Interview Guide for TANF/FS/MAO
- Form 713, Interagency/Interoffice Referral and Follow-Up
- Form 809, Verification of Earned Income and Deductions
- Form 990, Verification of Unearned Income

Administrative Review Forms

Administrative Review Forms are located in Appendix H, Administrative Reviews. These forms may be obtained by screen print or by ordering through the State Office. See instructions later in this section.

Administrative Review Forms include the following:

- Family Medicaid CAR Selection Guide
- Family Medicaid Reading Guide
- Form 965, ABD Medicaid Supervisory Review
- Form 974, ABD Medicaid Monthly Supervisory Review Summary Sheet
- Foster Care Supervisory Review Form
- IV-E Supervisory Review Summary
- Non-IV-E Supervisory Review Summary

Ordering Forms

Most Medicaid forms are available in MS Word format in Appendix F of the Medicaid Manual found in the Department of Human Services' On-Line Directives Information System (ODIS) www.odis.dhr.state.ga.us.

The Appendix F Table of Contents indicates how to obtain forms.

Screen Print Forms

Screen Print: The form must be printed when accessing ODIS. There is no central printing or storage of this form

DCH Forms

DCH forms should be ordered through the GAMMIS web portal following these procedures:

1. Go to www.mmis.georgia.gov
2. Click the “contact us” tab in the upper-right hand corner of the page.
3. Complete the information in the fields and click “submit”.

The e-mail must include the name and phone number of person ordering the form, the form number and quantity of forms requested, specifying English, Spanish or Braille and the shipping address.

Department of Homeland Security (DHS Forms)

DHS: This form must be printed from the following Department of Homeland Security web site: uscis.gov/graphics/formsfee/forms/files/g-845s.pdf

The instructions for use of the form are at the bottom of page two of the form. Once the form is

completed and documentation attached, the form should be mailed to:

U.S. Citizenship and Immigration Services Atlanta District
Martin Luther King, Jr.
Federal Building 77 Forsyth Street, SW
Atlanta, GA 30303

Forms OL

Forms OL: These forms must be printed when accessing DFCS Forms On-Line www.dfcs.dhr.georgia.gov/. From the DFCS home page, click on “About Us”. Then click on “Publications”. Then click on “DFCS Forms On-line”.

SSA Forms

SSA: Social Security Administration (SSA) forms must be printed from the following website:

EXCEPTIONS:

- Form SS-5 and instructions may be printed from the SSA website. The SS-5 is then submitted to the local SSA office either by mail or in person. The A/R must complete the form.

English version:
www.socialsecurity.gov/online/ss-5.pdf

Spanish version:
www.socialsecurity.gov/online/ss-5sp.pdf

- Form SS-1610-U2 must be ordered from the local SSA office.

N/A Forms

N/A: These forms are either generated by another agency or are reference only. Screen print is acceptable if available on ODIS.

Secretary of State Forms

Sec State: These forms must be ordered from the Secretary of State’s office at cfuller@sos.state.ga.us. The request should be to the attention of Carol Fuller. Fax requests must be made to 404-657-5367. The UPS shipping address and telephone contact number are required.

State Office Forms

SO: These forms must be ordered through the DFCS State Office.

PeachCare for KidsTM Forms

PeachCare for KidsTM applications and brochures can be ordered by using the PCK Special Request form located in Appendix F. This form can be emailed to sgreen@dch.ga.gov, or faxed to (770)344-3793.

Form 6(A) Physician’s Recommendation for Pediatric Care

Form 6Ai Instructions for Form DMA-6(A) Physician's Recommendation for Pediatric Care

Instructions

It is important that EVERY item on the DMA-6(A) is answered, even if it is answered as N/A (not applicable). Make sure that the physician or nurse who completes some of the sections is aware of this requirement. The form is only valid for 90 days from the date of the physician's signature. The form should be completed as follows:

Section A - Identifying Information

Section A of the form should be completed by the parent or the legal representative of the Katie Beckett child unless otherwise noted. All reference to "the applicant" means the child for whom Medicaid is being applied for.

Item 1: Applicant's Name/Address

Enter the complete name and address of the applicant including the city and ZIP code. For DFCS County enter the applicant's county of residence.

Item 2: Medicaid Number

To be completed by county staff.

Item 3: Social Security Number

Enter the applicant's nine-digit Social Security number.

Item 4 & 4A: Sex, Age and Birthdate

Enter the applicant's sex, age, and date of birth.

Item 5: Primary Care Physician

Enter the entire name of the applicant's Primary Care Physician.

Item 6: Applicant's Telephone Number

Enter the telephone number, including area code, of the applicant's parent or the legal representative.

Item 7: Does guardian think the applicant should be institutionalized?

If the Katie Beckett applicant were not eligible under this category of Medicaid, would s/he be appropriate for placement in a nursing facility or institution for the intellectually disabled.

Check the appropriate box.

Item 8: Does the child attend school?

Check the appropriate box.

Item 9: Date of Medicaid Application

To be completed by county staff.

Fields below Item 9:

Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, include the name of the caregiver.

Item 10: Signature

Read the statement below the name(s) of the caregiver(s), and then, the parent or legal representative for the applicant should sign the DMA-6(A) legibly.

Item 11: Date

Please record the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation

This section must be completed in its entirety by the Katie Beckett child's Primary Care Physician. No item should be left blank unless indicated below.

Item 12: History

Attach additional sheet(s) if needed.

Describe the applicant's medical history (Hospital records may be attached).

Item 13: Diagnosis

Add attachment(s) for additional diagnoses.

Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Please note the ICD codes. Depending on the diagnosis, a psychological evaluation may be required. If you have an evaluation conducted within the past three years, include a copy with this packet.

Item 13A: ICD-10 Diagnosis Code

Add attachment(s) for additional diagnoses.

Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines.

Item 14: Medications

Add attachment(s) for additional medication(s).

The name of all medications the applicant is to receive must be listed. Include name of drugs with dosages, routes, and frequencies of administration.

Item 15: Diagnostic and Treatment Procedures

Include all diagnostic or treatment procedures and frequencies.

Item 16: Treatment Plan

Attach copy of order sheet if more convenient or other pertinent documentation.

List previous hospitalization dates, as well as rehabilitative and other health care services the applicant has received or is currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization

List any anticipated dates of hospitalization for the applicant. Enter N/A if not applicable.

Item 18: Level of Care Recommended

Check the correct box for the recommended level of care; nursing facility or intermediate care facility for the intellectually disabled. If left blank or N/A is entered, it is assumed that the physician does not deem this applicant appropriate for institutional care.

Item 19: Type of Recommendation

Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

Item: 20: Patient Transferred From

Check one.

Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed

Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box for permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?

Check the appropriate box.

Item 23: Alternatives to Nursing Facility Placement

The admitting or attending physician must indicate whether the applicant's condition could be managed by provision of the Community Care or Home Health Care Services Programs. Check

either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate.

Item 24: Physician's Name and Address

Print the admitting or attending physician's name and address in the spaces provided.

Item 25: Certification Statement of the Physician and Signature

The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility or an intermediate care facility for the intellectually disabled.

This must be an original signature; signature stamps are not acceptable.

If the physician does not deem this applicant appropriate for institutional care, enter N/A and sign.

Item 26: Date Signed by the Physician

Enter the date the physician signs the form.

Item 27: Physician's Licensure Number

Enter the attending or admitting physician's license number.

Item 28: Physician's Telephone Number

Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed

Check appropriate boxes only.

This section may be completed by the Katie Beckett child's Primary Care Physician or a registered nurse who is well aware of the child's condition.

Items 29 - 38

Check each appropriate box.

Item 39: Other Therapy Visits

If applicable, check the appropriate box for the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.

Item 40: Remarks

Enter additional remarks if needed or "None".

Item 41: Pre-admission Certification Number

Leave this item blank.

Item 42: Date Signed

Enter the date this section of the form is completed.

Item 43: Print Name of MD or RN/Signature of MD or RN

The individual completing Section C should print their name legibly and sign the DMA-6(A).

This must be an original signature; signature stamps are not acceptable.

Items 44 - 52

Do Not Write Below This Line.

Items 44 through 52 are completed by Contractor staff only.

Form 7 Level of Care Reevaluation for NOW/COMP

Form 94 Medicaid Application

Form 94 SP Medicaid Application (Spanish)

Form 94A Medicaid Streamlined Application

Form 94A SP Medicaid Streamlined Application (Spanish)

Form Streamlined Application Appendix A

Form Appendix A LP Streamlined Application Appendix A (Large Print)

Form Appendix A SP Streamlined Application Appendix A (Spanish)

Form Appendix A SP LP Streamlined Application Appendix A (Large Print) (Spanish)

Form Streamlined Application Appendix B

Form Appendix B LP Streamlined Application Appendix B (Large Print)

Form Appendix B SP Streamlined Application Appendix B (Spanish)

Form Appendix B SP LP Streamlined Application Appendix B (Large Print) (Spanish)

Form Streamlined Application Appendix C

Form Appendix C LP Streamlined Application Appendix C (Large Print)

Form Appendix C SP Streamlined Application Appendix C (Spanish)

Form Appendix C SP LP Streamlined Application Appendix C (Large Print) (Spanish)

Form Appendix D Pathways Program

Form 106 Insurance Clearance

Form 107 SSI Status Change

Form 109 SSI Cont Med Determination Notice (ExParte Cover letter)

Form 109 SP SSI Continuing Medicaid Determination (Ex Parte Cover letter) (Spanish)

Form 118 SP Request for a Hearing-(Spanish)

Form 124 Application for Health Insurance

124i Instructions for Form DMA 124: Application for HIPP Program

Instructions

Step 1 Head of Household

Provide the name of the head of household and address and telephone number where he or she may be contacted if additional information or data verification is required.

Step 2 Referral Source

Provide the name and address of the person completing the application. A copy of the decision on the application will be returned to the referral source.

Step 3 **Complete the following information regarding your health insurance policy.**

If known, complete insurance information is helpful. Enter the complete name of the policy holder, BOTH the insurance group number, if applicable, and policy number, if applicable, address and telephone number of the insurance company. This information is usually available on the member's insurance card.

Step 4 **What is the annual Maximum Out of Pocket Expense?**

If known, enter the maximum out-of-pocket expense per individual and for the entire family. The out-of- pocket expense should not be confused with the lifetime limit of the policy. The lifetime limit is the maximum amount of coverage offered by the policy.

Step 5 **Is the deductible included in the out of pocket expense?**

If the annual deductible amount is included in the out-of-pocket expense, check "Yes". If not, check No".

Step 6 **What is the annual deductible?**

If known, enter amount of the annual deductible. If unknown, leave blank.

Step 7 **Is this policy an HMO or PPO?**

If known, check "Yes" if the policy is an HMO or PPO and "NO" if not. If unknown, leave blank.

Step 8 **Complete the following information regarding the employer offering this policy.**

Provide employers name, address and telephone number**. Please do not provide the employee's direct phone number.

**We will need to verify information with the employer and not the employee.

Step 9 **List all Medicaid eligible persons covered under this policy.**

List all persons living at this address who are Medicaid eligible and eligible for coverage under this policy. Enter the full name, Social Security Number, date of birth, Medicaid identification number, relationship to the policy holder and gender for each person. If there are more than five persons, attach a second form.

Step 10 **Are any of these persons pregnant?**

If any person in Step 9 above is pregnant, check "Yes" and enter the expected delivery date. If none are pregnant, check "No".

Step 11 **Have any of the persons in Step 9 above been diagnosed with a medically expensive condition?**

If any person in Step 9 above is currently diagnosed with a medically expensive condition, enter the individual's name and the diagnosis. If no medically expensive conditions exist, enter "No". Medical conditions include but are not limited to: Diabetes, Blood Disorder, Cancer, Mental Illness/Retardation, Heart Condition, Asthma, Scoliosis or other Back Injury, Stroke, Seizure Disorder, Kidney/Liver Disorder, Alcohol/Drug Addiction, HIV Positive/AIDS.

Step 12 **How much are the premiums for this policy?**

Enter the amount the policy holder pays for insurance coverage. Check the frequency of premium payments.

Step 13 **Check the services covered under this policy**

Hospital: Medical inclusive of room and board charges Physician: Professional services offered by physicians Pharmacy: Drugs and pharmaceuticals

Dental: Oral care - both routine and emergency

Home Health: Care and services provided in the insured person's home Long Term Care: Care provided in a non acute setting i.e. Nursing Facility

This information is best obtained directly from the insurance carrier. If you do not have access to the carrier and do not know the information, leave blank.

Step 14 **Complete the following information if COBRA benefits might be available**

If the policy holder is eligible for COBRA benefits, check “Yes” if COBRA forms have been received, and “No” if none received. If “Yes”, enter date received. Enter the last employment date. Indications of COBRA coverage might be a recent job termination, recent layoff from a job or a new job where the benefits do not cover a pre-existing condition.

Step 15 **Can we contact your employer and/or insurance carrier to verify this information?**

Check “Yes” if the employer and/or insurance company can be contacted for verification. If “No” is checked, the application will be denied for insufficient information to process the application.

Step 16 **Has the applicant or any dependents been involved in an accident?**

Check “Yes” if the applicant or any of the dependents listed were involved or injured in an accident that required medical attention within the last 12 months. If an attorney or insurance company is involved, please obtain this information and note it on the application. If no accidents occurred, please check “NO”

Step 17 **Sign and date this application.**

The applicant does not have to be the policy holder. However, the policyholder must sign and date the application upon completion. Please mail the completed application to the following address:

HIPP Unit
5660 New Northside Drive Suite 750
Atlanta, GA 30328-5829

Should you have any questions, you may contact the HIPP Unit directly at 770-980-9777.

Form 129 Recipient Notice for Spousal Impoverishment

Form 130 TANF and Family Medicaid Child and Medical Support Letter

Form 136 County Request for Final Appeal

Form 138 Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate with DCSS

Georgia Department of Human Services

Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Services and Third Party Liability Requirements

Benefits of Child Support Services

Your help in the child support services process may be of value to you and your child because it may result in:

- Finding the absent parent.
- Legally establishing your child's paternity.
- Receipt of child support payments that may give you more money than if you receive Temporary Assistance for Needy Families (TANF).
- Acquisition of private health insurance through the absent parent.
- Acquisition of rights to future Social Security, veterans or other government benefits.

Cooperation with DFCS and DCSS

The law requires you to help the Division of Family and Children Services (DFCS) and the Division of Child Support Services (DCSS) get any support owed to you and the children for whom TANF is requested, unless you have good cause for not helping.

In helping DFCS or DCSS, you must do one or more of the following:

- Name the absent parent(s) of any child for whom you are requesting TANF or Medicaid.
- Provide information to help find the absent parent(s).
- Help determine who the legal father is if your child was born out of wedlock.
- Agree to have a blood test if the person you name as the father denies paternity.
- Help the state get money owed to you and/or the child who receives TANF.
- Provide information about medical insurance the absent parent has on your child.

You must come to the DFCS office, DCSS or court to sign papers or provide needed information.

Good Cause

You may have good cause for not wanting to help DCSS collect child support or medical coverage for your child. You may not have to help if you believe helping is not in your child's best interest, and if you can prove it. If you want to claim good cause, you must tell your worker. You can do this at any time.

If You Do Not Help and Do Not Have Good Cause

- You will not be eligible to receive TANF for yourself and your child.
- Your child may still be eligible for Medicaid.

Good Cause Reasons

You may claim good cause for any of the following reasons:

- Your help may cause serious physical or emotional harm to your child or to you.
- The child was born as a result of rape or incest.
- Court proceedings are underway for adoption of the child.
- An agency is helping you to decide whether to place the child for adoption.

To Prove Good Cause, You Must

- give DFCS information it needs to decide if you have good cause for not helping. If you fear physical harm and cannot get proof, DFCS may still be able to make a good cause determination.
- give proof to DFCS within 20 days of claiming good cause. DFCS will give you more time only if you have trouble getting proof.

DFCS may excuse you from helping based on the information you provide. Or, DFCS may ask you to provide more information. DFCS will not contact the absent parent without telling you.

If you are applying for TANF, you will not be approved until you give DFCS proof of your claim of good cause or the information DFCS needs to investigate your claim.

Examples of Proof of Good Cause

- birth certificate, medical or law enforcement records showing that the child was born as a result of rape or incest
- court or other legal documents showing that adoption proceedings have begun
- court, medical, criminal, child protective services, social services, psychological or law enforcement records showing that the absent parent may hurt you or the child
- medical records or written statements from a mental health professional showing the history and current status of your and/or the child's emotional health
- a written statement from a public or private agency showing you are being helped to decide whether to give your child up for adoption
- sworn statements from friends, neighbors, clergy, social workers, or medical professionals who know why you have good cause.

If you need help in getting any of the documents, ask your worker.

Child Support Rules

If you receive TANF, you give the state of Georgia, by law, any rights you have to receive child support. Once the court order is established, the absent parent will be required to pay child support through DCSS. After the court order is established, you will be required to report any money you receive directly from the absent parent. You must also help establish paternity for your child and cooperate with DCSS in establishing a child support order. If you do not cooperate and do not have good cause, you may not be eligible for TANF.

If you receive TANF and the absent parent pays child support through the Division of Child Support Services (DCSS), you probably will NOT receive the full amount of the child support payment. Instead, you may receive a "gap" payment. All child support paid by an absent parent, which is in excess of the "gap" amount, is retained by DCSS and is used to pay back the TANF funds that you have received. ***Your TANF case manager can explain gap budgeting and the payment procedures to you.***

If your TANF case is closed, child support payments will be sent to you up to the amount of the absent parent's current monthly obligation. Any child support amount paid over the current obligation will be kept by the state to repay past TANF grants received by you. Once the past TANF grants are repaid, you will be sent all child support paid by the absent parent.

If your TANF case is closed and *then* reopened, any child support back payments due you will be assigned to the State up to the amount of all TANF money you have ever received. When the Unreimbursed Public Assistance (UPA) is repaid, then you will start receiving any back payments owed to you.

If you receive child support payments to which you are not entitled, you may have to repay the state. The state will notify you of the amount of the overpayment and the timeframe for repayment.

DCSS may review the DFCS good cause decision in your case. If you request a hearing about the decision, DCSS may participate in the hearing.

If you have good cause for not helping, DCSS will not try to establish paternity or collect child support.

I have read this notice about my rights to claim good cause and not helping to establish paternity or to collect child support from the absent parent.

_____ Signature of Applicant/Recipient

_____ Date

I have provided the TANF or Medicaid applicant/recipient with a copy of this notice.

_____ Signature of Case Manager

_____ Date

Revision Date: 10/2012

Form 138 SP Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate with DCSS(Spanish)

Departamento de Servicios Humanos de Georgia

Notificación de requerimiento de colaboración y derecho a alegar causa justa de negativa a la colaboración para exigir el cumplimiento de la obligación de suministrar manutención infantil y requerimientos de recursos de terceros

Beneficios derivados del cumplimiento de la obligación de suministrar manutención infantil

Su colaboración en el proceso destinado a exigir el cumplimiento de la obligación de suministrar manutención infantil puede ser valioso para usted y para su hijo ya que puede permitir:

- Encontrar al padre ausente.
- Establecer legalmente la paternidad de su hijo.
- Recibir pagos de manutención infantil que puedan facilitarle más dinero que si recibe Asistencia Temporaria para Familias Necesitadas (TANF, por sus siglas en inglés).
- Adquirir seguro médico privado a través del padre ausente, y
- Adquirir derecho a la obtención de futuros beneficios derivados de la Seguridad Social, beneficios para veteranos de guerra y otros beneficios.

Colaboración con la DFCS y la OCSS

La ley requiere que usted colabore con la División de Servicios para Familias y Niños (DFCS, por sus siglas en inglés) y Oficina de Servicios de Manutención Infantil (OCSS, por sus siglas en inglés) para obtener las prestaciones que le corresponden a usted y a los hijos por los cuales solicita la TANF, excepto que exista causa justa para no prestar dicha colaboración.

Al colaborar con la DFCS o la OCSS, usted debe realizar uno o más de los siguientes actos:

- Consignar el nombre del padre ausente del hijo por el cual solicita la TANF y /o Medicaid.
- Proporcionar información para localizar al padre ausente.
- Ayudar a determinar quién es legalmente el padre si se trata de un hijo extramatrimonial.
- Aceptar que se le realice un análisis de sangre si la persona que usted indicó como padre niega su paternidad.
- Ayudar al estado a obtener el dinero adeudado a usted y/o al hijo que recibe la TANF.
- Proporcionar información acerca del seguro médico que el padre ausente posee sobre su hijo.

Usted debe presentarse en las oficinas de la DFCS, la OCSS o ante el tribunal para firmar documentación o proporcionar la información necesaria.

Causa Justa

Es posible que usted posea una causa justa para no desear colaborar con la OCSS para percibir manutención infantil o cobertura médica para su hijo. Es posible que no tenga que colaborar si usted considera que no resulta en beneficio de su hijo y si puede probarlo. Si desea alegar causa justa, es necesario que se lo mencione a su trabajador. Puede hacerlo en cualquier momento.

Si usted no colabora y no posee una causa justa

- No cumplirá los requisitos para recibir la TANF para usted y para su hijo.
- Su hijo puede aún cumplir los requisitos para recibir Medicaid.

Razones de causa justa

Puede alegar causa justa en razón de cualquiera de los siguientes motivos:

- Su colaboración podría provocar daños físicos o emocionales graves a su hijo o usted.
- Su hijo nació como resultado de violación o incesto.
- Se encuentra en trámite un proceso judicial para la adopción de su hijo.
- Un organismo colabora con usted para decidir si dar a su hijo en adopción.

Para probar causa justa usted debe:

- Proporcionar a la DFCS la información necesaria para decidir si existe causa justa para negarse a colaborar. Si teme sufrir daños físicos y no puede reunir las pruebas, la DFCS podrá igualmente efectuar una determinación de causa justa.
- Brindar pruebas a la DFCS dentro de los 20 días de haber alegado causa justa. La DFCS le brindará más tiempo sólo si usted posee inconvenientes para obtener las pruebas.

La DFCS puede eximirlo de la obligación de colaborar en cuanto a la información que usted brinde. La DFCS puede también solicitarle que proporcione mayor información. La DFCS no contactará al padre ausente sin avisarle a usted al respecto.

NOTA: Si usted solicita la TANF, su solicitud no será aprobada hasta que proporcione pruebas a la DFCS de causa justa o la información que la DFCS necesita para investigar su situación.

EJEMPLOS DE PRUEBA DE CAUSA JUSTA

- Certificado de nacimiento, registros médicos o legales que demuestren que el niño nació como consecuencia de violación o incesto.
- Documentación judicial o legal que demuestre que se ha iniciado el proceso de adopción.
- Servicios judiciales, médicos, penales, de protección de menores, servicios sociales, registros psicológicos o legales que demuestren que el padre ausente puede lastimarlo a usted o su hijo.
- Registros médicos o declaraciones escritas de un profesional de salud psíquica que demuestren la historia y estado actual de su salud emocional y/o la de su hijo.
- Declaración escrita de un organismo público o privado que demuestre que usted recibe asisten-

cia para decidir si dar o no a su hijo en adopción.

- Declaraciones juradas de amigos, vecinos, sacerdotes, trabajadores sociales o profesionales médicos que sepan por qué usted posee causa justa.

Si necesita ayuda para obtener cualquiera de los documentos, consulte con su trabajador.

Normas sobre suministro de manutención infantil

Si usted recibe la TANF, usted proporciona al estado de Georgia, por ley, cualesquiera derechos que usted posea a recibir manutención infantil. Una vez que se establece la orden judicial, el padre ausente deberá pagar manutención infantil a través de la OCSS. Luego de que se establezca la orden judicial, usted deberá informar todo el dinero que perciba directamente del padre ausente. Usted deberá, asimismo, colaborar para establecer la paternidad de su hijo y colaborar con la OCSS para establecer una orden de suministro de manutención infantil. Si usted no colabora y no posee justa causa para ello, es posible que no reúna los requisitos para obtener la TANF.

Si usted recibe la TANF y el padre ausente paga manutención infantil a través de la Oficina de Servicios de Manutención Infantil (OCSS), es probable que usted NO reciba el monto total del pago de manutención infantil. En cambio, es posible que usted reciba un pago “de diferencia”. Todos los pagos por manutención infantil efectuados por un padre ausente que superen el monto "de diferencia" serán retenidos por la OCSS y se utilizarán para devolver los fondos de la TANF que usted recibió. ***El encargado de su caso TANF puede explicarle las diferencias y los procedimientos de pago.***

Si se cierra su caso TANF, los pagos de manutención infantil le serán enviados hasta el monto de la obligación mensual actual del padre ausente. Los montos de manutención infantil pagados que superen la obligación actual serán retenidos por el estado para devolver las asignaciones anteriores de TANF que usted haya recibido. Una vez devueltas las asignaciones TANF pasadas, se le enviará la totalidad del pago por manutención infantil efectuado por el padre ausente.

Si su caso TANF se cierra y *luego* se abre nuevamente, los pagos por manutención infantil retroactivos que se le adeuden serán asignados al Estado hasta el monto de la totalidad del dinero TANF que usted haya percibido. Cuando se haya devuelto la Asistencia Pública No Reembolsada (UPA, por sus siglas en inglés), usted comenzará a percibir cualesquiera pagos adeudados.

Si usted percibe pagos de manutención infantil a los cuales no posee derecho, es posible que usted deba efectuar devoluciones al estado. El estado lo notificará acerca del monto del pago en exceso y acerca del plazo para efectuar la devolución.

La OCSS puede revisar la decisión de la DFCS sobre causa justa en su caso. Si usted solicita una audiencia acerca de la decisión, la OCSS podrá participar de la audiencia.

Si posee causa justa para no colaborar, la OCSS no efectuará intentos por establecer la paternidad o percibir manutención infantil.

Declaro haber leído la presente notificación acerca de mis derechos a alegar causa justa y no colaborar para establecer Ia paternidad o percibir manutención infantil por parte del padre ausente.

_____ Firma del Solicitante/Destinatario

_____ Fecha

Declaro haber proporcionado copia de la presente notificación al solicitante/destinatario de TANF o Medicaid.

_____ Firma del Encargado del Caso

_____ Fecha

Revision Date: 12/2008

Form 139 Contribution Statement

Form 139 SP Contribution Statement (Spanish)

Form 171 Parent to Child Deeming Worksheet

Form 172 ABD MAO Individual/Couple/Spouse to Spouse Deeming

172i Instructions for Form 172 ABD MAO Individual / Couple / Spouse to Spouse Deeming Budget Sheet

Complete this budget sheet when the A/R resides in LA-A or LA-B and is applying for ABD Medicaid as an individual (Section A only), as an individual with a Medicaid ineligible spouse (Sections A, B and C) or as a couple (Section C only). Do not use Form 172 for a SSI Trial budget for Katie Beckett children. Use the Form 171, ABD Medicaid Parent to Child Deeming Budget Sheet, to test for potential SSI eligibility for a child.

Section A: Use only for individuals or individuals with ineligible spouse.

Unearned Income:

1. Enter the A/R's gross unearned income, not allowing for any deductions except those listed in Section 2405 under "Income Not Included in Determining Financial Eligibility". Consider any In Kind Support and Maintenance (ISM) for the A/R as unearned income. Refer to Section 2430.
2. Enter the $20 general deduction unless the income is Income Based on Need (IBON). To determine if the income is IBON, refer to Sections 2505, Income Deductions, and 2499, Treatment of Income. If income is IBON, enter 0.
3. Subtract line 2 from line 1 and enter the result in line 3. This is considered the A/R's net countable unearned income.

Earned Income:

4. Enter the A/R's gross earned income not allowing for any deductions except those listed in Section 2505, Income Deductions.
5. If all of the $20 general deduction was not used for the Unearned Income budget above, enter the remainder of the $20 in line 5. Otherwise enter 0.
6. Subtract line 5 from line 4 and enter the result in line 6.
7. Enter $65 in line 7.
8. Subtract line 7 from line 6 and enter the result in line 8.
9. Compute 1/2 of line 8 and enter the result in line 9.
10. Subtract line 9 from line 8 and enter the result in line 10. This is the net countable earned income for the A/R.

Total Income:

11. Enter the sum of line 3 and line 10 in line 11.
12. Enter the individual income limit for the COA for which the A/R is applying. For AMN, enter the individual MNIL. See Appendix A1.
13. Subtract line 12 from line 11.
    a. If a negative number is the result, the individual with no spouse is eligible for the COA.
    b. If a negative number is the result, and the individual with no spouse has applied for AMN, the individual is defacto eligible.

c. If the individual with no spouse is applying for QMB, the result may be zero or a negative number to be eligible.

d. If a positive number is the result, the individual is ineligible for any COA except AMN. Do not proceed to Section B unless applying for AMN.

e. If a positive number is the result and the individual is applying for AMN, the result is the spendown amount for an individual with no spouse, or the 1st potential spenddown amount for an individual with an ineligible spouse. Proceed to Section B for individual with an ineligible spouse.

f. If the A/R is applying as an individual with an ineligible spouse and the result was a negative number, proceed to Section B.

Section B: Use only for individuals with an ineligible spouse.

Unearned Income:

1. Enter the ineligible spouse's gross unearned income, not allowing for any deductions except those listed in Section 2405 under "Income Not Included in Determining Financial Eligibility".
2. If there are child(ren) in the home, enter the child(ren)'s income minus the living allowance for each child. See Appendix A1.
3. Subtract line 2 from line 1 and enter the result in line 3. This is considered the ineligible spouse's net countable unearned income.

Earned Income:

4. Enter the ineligible spouse's gross earned income, not allowing for any deductions except those listed in Section 2505, Income Deductions.
5. Enter the amount of any living allowance not subtracted from unearned income. This would have been a negative number in Step 3 above.
6. Subtract line 5 from line 4 and enter the result in line 6. This is the net countable earned income for the ineligible spouse.

If the individual is potentially AMN and the combined total of the amounts on line B.3 and B.6 is less than or equal to one-half of the MNIL for an individual, discontinue budgeting and use the amount from line A.13 as the AMN spenddown. It will not be necessary to proceed with Section C.

Section C: Use only for individuals with ineligible spouse or for Medicaid couples.

Unearned Income:

1. If this is a Medicaid couple situation, enter the couple's gross unearned income, not allowing for any deductions except those listed in Section 2405 under "Income Not Included in Determining Financial Eligibility".

If this is a Medicaid individual with an ineligible spouse, enter the sum of line A.1 and line B.3.

2. Enter the $20 general deduction unless the income is Income Based on Need (IBON). To deter-

mine if the income is IBON, refer to Sections 2505, Income Deductions, and 2499, Treatment of Income. If income is IBON, enter 0.

3. Subtract line 2 from line 1 and enter the result in line 3. This is considered the couple's net countable unearned income or the individual's net countable unearned income including the income deemed from the ineligible spouse.

Earned Income:

4. If this is a Medicaid couple situation, enter the couple's gross earned income not allowing for any deductions except those listed in Section 2505, Income Deductions.

If this is a Medicaid individual with an ineligible spouse, enter the sum of line A.4 and line B.6.

5. If all of the $20 general deduction was not used for the Unearned Income budget above, enter the remainder of the $20 in line 5. Otherwise enter 0.
6. Subtract line 5 from line 4 and enter the result in line 6.
7. Enter $65 in line 7.
8. Subtract line 7 from line 6 and enter the result in line 8.
9. Compute 1/2 of line 8 and enter the result in line 9.
10. Subtract line 9 from line 8 and enter the result in line 10. This is the net countable earned income for the A/R with income deemed from ineligible spouse or the net countable earned income for the Medicaid couple.
11. Enter the sum of line C. 3 and line C. 10 in line 11.
12. Enter the couple income limit for the COA for which the individual/couple is applying. For AMN, enter the couple MNIL. See Appendix A1.
13. Subtract line 12 from line 11.
    a. If a negative number is the result, the individual with ineligible spouse or the couple is eligible for the COA. Exception: If a negative number is the result and the individual with ineligible spouse has applied for Q track, the individual must have been eligible for same or higher level of Q Track in
14. 13 to be eligible for the Q Track shown in line C. 13. See Note on Form 172.
15. If a negative number is the result, and the individual with an ineligible spouse or the couple has applied for AMN, the individual/couple is defacto eligible.
16. If the individual with an ineligible spouse or a couple is applying for QMB, the result may be zero or a negative number to be eligible. See Exception in (a) above.
17. If a positive number is the result, the individual with an ineligible spouse or the couple is ineligible for any COA except AMN.
18. If a positive number is the result and the individual with an ineligible spouse is applying for AMN, the result is the spendown amount if it is greater than the amount in A.13. If the amount in A.13 is greater, that is the spenddown amount.
19. If a positive number is the result and the couple is applying for AMN, the result is the spendown amount.

Form 173 Verification Checklist

173i Instructions for Form 173: Verification Checklist

Purpose

Form 173 is used to request information and verification needed to determine eligibility.

Source

Form 173 is printed on NCR paper and is available by order from the State office. If hard copies of the Form 173 are temporarily unavailable, this form is also available online at Form 173 and may be printed locally.

Instructions

Complete the basic case and client specific information at the top of the form. Enter the client's name and mailing address in the upper left portion of the form if the form is being mailed to the AU.

Complete the remainder of the form as needed.

Mail or give the original to the AU, file the copy in the case record.

Form 173 SP Verification Checklist (Spanish)

Form 174 SMEU Medical Records Cover Letter

Form 185 Affidavit of Paternity

Form 214 Medicaid Notification

Form 214 SP Medicaid Notification Form (Spanish)

Form 216 Declaration of Citizenship Eng/SP

Form 217 Affidavit to Establish Identity for Medicaid Applicant/Recipients < 16

Form 217 SP Affidavit to Establish Identity for Medicaid Applicant/Recipients < 16 (SP)

Form 218 Citizenship/Identity Verification Checklist

AU NAME: _____

AU NUMBER: _____

CITIZENSHIP/IDENTITY VERIFICATION CHECKLIST

CITIZENSHIP/IDENTITY MUST BE VERIFIED FOR ALL MEDICAID APPLICATIONS/RENEWALS

If you have already provided acceptable verification of your citizenship/identity as listed below, or are a recipient of SSI or Medicare further verification is not necessary. Please check with the DFCS Customer Service line or your local county DFCS office for clarification.

Please provide one of the following, and return using the contact information on the verification checklist.

No Identity Required on these Citizenship Verifications:

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

Identity Required with these Citizenship Verifications:

- US Public Birth Record showing birth in one of the 50 states; District of Columbia; American Territories; or Guam
- US birth certificate or data match with a State Vital Statistic Agency
- Certification of Report of Birth (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the U.S.(FS-240)
- Certification of Birth Abroad (FS-545)
- United States Citizen Identification Card (I-197 or the prior version I-179)
- American Indian Card (I-872) with the classification “KIC” (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
- Collective Naturalization document/Northern Mariana Identification Card (I-873)
- Final Adoption Decree
- Evidence of civil service employment by the US government
- Official Military record
- Federal or State census record showing US citizenship indicating a US place of birth
- Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs
- Statement signed by the physician or midwife who was in attendance at the time of birth
- One of the following documents created at least 5 years before the application for Medicaid showing a US place of birth:

- Extract of hospital record on hospital letterhead established at the time of person's birth
- Life, health or other insurance record
- An amended US public birth record
- Medical clinic(not Health Dept.), doctor or hospital record indicating a US place of birth
- Institutional admission papers from nursing home, skilled nursing care facility or other institution

If you do not have any of the above, please contact the DFCS Customer Service line or your local county DFCS office to complete an affidavit of citizenship or identity.

Acceptable Verification of Identity:

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

For individuals under age 16 who are unable to produce a document listed above, the following documents are acceptable to establish identity only:

- School record including report card, daycare or nursery school record. (Must verify record with issuing school)
- Clinic, doctor or hospital record showing date of birth. The Form 3231 immunization record from the Department of Public Health (DPH) is acceptable if an immunization date on the form was documented before the individual's 16th birthday.
- Affidavit signed under penalty of perjury by a parent/guardian. (**Contact the DFCS Customer Service line or your local county DFCS office**.)
- A signed Declaration of Citizenship form that includes the date and place of birth of the child. (**Contact the DFCS Customer Service line or your local county DFCS**.)
- All documents that verify citizenship/identity must be either ORIGINALS or copies CERTIFIED by issuing agency.

Revision Date: 01/14

Form 218 SP Citizenship/Identity Verification Checklist (Spanish)

NOMBRE DE UNIDAD DE ASISTENCIA (AU): _____

NÚMERO DE AU: _____

LISTA DE CONTROL PARA LA VERIFICACIÓN DE CIUDADANÍA/IDENTIDAD

SE DEBE VERIFICAR LA CIUDADANÍA/IDENTIDAD DE TODAS LAS PERSONAS QUE SOLICITAN/RENUEVAN LOS BENEFICIOS DE MEDICAID

Si ya proporcionó verificación aceptable de su ciudadanía/identidad como se indica a continuación, o si recibe Ingresos de Seguro Suplementario (SSI) o Medicare no es necesario presentar otro documento para la verificación. Si necesita alguna aclaración, consulte por teléfono a la línea de Servicio al Cliente de DFCS o con la oficina DFCS de su condado local.

Recuerde presentar uno de los siguientes documentos y devuelva usando la información de contacto que figura en la lista de control para la verificación.

No es necesario comprobar la identidad en los siguientes documentos para verificar la ciudadanía:

- Pasaporte de EE. UU. (no se permiten pasaportes con limitaciones)
- Certificado de Naturalización (N-550 o N-570)
- Certificado de Ciudadanía (N-560 o N-561)

Es necesario comprobar la identidad en los siguientes documentos para verificar la ciudadanía:

- Registro público de nacimiento en EE. UU. que indique el nacimiento en uno de los 50 estados, Distrito de Columbia, Territorios de EE. UU. o Guam
- Certificado de nacimiento en EE. UU. o información que concuerde con la Agencia Estatal de Estadísticas Vitales
- Certificado de Informe de Nacimiento (DS-1350)
- Informe Consular de Nacimiento en el Extranjero de un Ciudadano de EE. UU. (FS-240)
- Certificado de Nacimiento en el Extranjero (FS-545)
- Tarjeta de Identificación de Ciudadano de los Estados Unidos (I-197 o la versión anterior I-179)
- Tarjeta de Indígena de EE. UU. (I-872) con la clasificación “KIC” (Emitida por DHS para identificar ciudadanos de EE. UU. miembros de la Banda de Kickapoos de Texas que viven cerca de la frontera entre EE. UU. y México)
- Documento de Naturalización Colectiva/Tarjeta de Identificación de las Islas Marianas del Norte (I-873)
- Decreto Final de Adopción

- Comprobante de empleo en el servicio civil por parte del gobierno de EE. UU.
- Registro oficial militar
- Registro del censo federal o estatal donde se establezca ciudadanía de EE. UU y se indique lugar de nacimiento en EE. UU.
- Registro de censo tribal de la tribu Seneca o de la Oficina de Asuntos Indígenas
- Declaración firmada por un médico o partera que estuvo presente en el momento del nacimiento
- Uno de los siguientes documentos creados al menos 5 años antes de solicitar Medicaid que indiquen un lugar de nacimiento en EE. UU.:
    - Extracto del registro del hospital en papel con membrete del hospital emitido en el momento del nacimiento de la persona
    - Registro de seguro de vida, de salud u otro tipo de cobertura
    - Registro público de nacimiento en EE. UU. que haya sido enmendado
    - Registro de clínica médica (no del Departamento de Salud), registro médico o registro de hospital que indique un lugar de nacimiento en EE. UU.
    - Documentos de admisión institucional a una casa de salud, centro de atención de la salud u otra institución

Si no tiene ninguno de los documentos previamente enumerados, comuníquese con la línea del Servicio al Cliente de DFCS o con la oficina DFCS de su condado local para completar una declaración jurada de ciudadanía o identidad.

Verificación aceptable de identidad:

- Licencia de conducir emitida por el estado con la fotografía de la persona **o** Tarjeta de Identificación del Estado de Georgia
- Certificado de Sangre Indígena, documento emitido por tribu indígena de EE. UU./Alaska o documento emitido por tribus indígenas de EE. UU.
- Tarjeta militar de EE. UU. o registro de servicio militar, tarjeta de identificación con fotografía de dependientes de personal militar, tarjeta de marino mercante de la Guardia Costera de EE. UU.
- Tarjeta de identificación emitida por agencias o entidades del gobierno a nivel federal, estatal o local con fotografía o información de identificación personal
- Tarjeta de identificación escolar con fotografía
- Pasaporte de EE. UU. emitido con limitaciones
- Datos obtenidos o documentos de agencias del orden público o establecimientos penitenciarios, como el departamento de policía o del sheriff, oficina de libertad condicional, Departamento de Justicia para Menores (DJJ) y Centros de Detención Juvenil

En el caso de personas menores de 16 años que no pueden presentar ninguno de los documentos enumerados previamente, se aceptan los siguientes documentos como comprobantes de identidad solamente:

- Registro escolar, incluido el la tarjeta de notas, registro del centro de cuidado infantil o del programa preescolar. (Se debe verificar el registro con la escuela que emite el documento)
- Registro de la clínica, del médico o del hospital que indica la fecha de nacimiento. Se acepta el registro de vacunas (formulario 3231) emitido por el Departamento de Salud Pública (DPH) si se registró una fecha de vacunación en el formulario antes de que la persona cumpliera 16 años de edad.
- Declaración jurada bajo pena de perjurio por el padre/madre/tutor legal. (**Comuníquese con la línea de Servicio al Cliente de DFCS o con la oficina DFCS de su condado local**.)
- Formulario firmado de la Declaración de Ciudadanía que incluya la fecha y el lugar de nacimiento del menor. (**Comuníquese con la línea de Servicio al Cliente de DFCS o con la oficina DFCS de su condado local**.)
- Todos los documentos presentados para verificar la ciudadanía/identidad deben ser ORIGINALES o copias CERTFICADAS emitidas por la agencia correspondiente.

Revision Date: 01/14

Form 219 Affidavit of Facts Concerning Citizenship

Form 219 SP Affidavit of Facts Concerning Citizenship (Spanish)

Form 223 Medicaid and IV-E Application for Foster Care

223i Instructions for Form 223: Medicaid and IV-E Application for Foster Care and Adoption Assistance

Purpose

Form 223 is to be used by the SSCM/JPPS to apply for Medicaid and to request a IV-E determination on behalf of a foster care or adoption assistance child. An application should be completed and filed for **each** child who comes into foster care within five (5) working days of the child's placement regardless of the length of stay. Provide information for all questions to the extent possible.

Instructions

APPLICANT CHILD INFORMATION: The child's name should be listed as it appears on the Social Security Identification card. Registration of an application using a nickname or incomplete name may cause problems with the payment of Medicaid claims. The screening process on SUCCESS should be thorough. It is important that a new identification number not be given if the child already has a client number assigned in the system.

The fields for SSN, date of birth, gender, race, and citizenship are self-explanatory. Provide all information known on child's mother and father including address, SSN, race, DOB, legal relationship, paternity and court ordered child support.

MEDICAID INFORMATION SECTION:

If the child has returned home prior to making application, the entire form is completed and faxed to the appropriate Revenue Maximization Regional Office and not to the Revenue Maximization Intake Unit.

County: enter custody county

Removal Date: enter removal date

Prior Months MAO? Is Medicaid needed for any of the three months prior to the application month? List month(s).

If Medicaid is being requested for any of the three months prior to the application month, complete a separate Form 224 for the application month and for each month of retroactive MAO requested.

Questions 1 and **2** are self-explanatory and are addressed with Form 224, Removal Home – Income and Asset Checklist, which should accompany the IV-E Information Section. However, if only the form 223 is used, income should be entered as gross income.

Question 3 is self-explanatory. A copy of verification of pregnancy and estimated date of delivery must be faxed with this form if available. If not, notate medical provider and telephone number for verification.

Question 4 is self-explanatory. A copy of the insurance card, if available, should be attached to the Form 223 and faxed with the form.

The form should be signed and dated by the SSCM/JPPS with printed name and the fax num-

ber.

Fax form and required documentation to the Revenue Maximization Intake Unit at 770-473-2620.

IV-E INFORMATION SECTION:

Initial court orders faxed: Revenue Maximization records are now required to have copies of all pertinent court orders. Have the initial court orders been faxed to the appropriate Rev Max MES?

Question 4a. List the name of the person the child was physically living with at the time of the removal.

Question 4b. Indicate if the person named in 4a. is a parent, specified relative within the degree of relationship, or other. If specified relative or other is checked, explain the relationship to the child.

Question 4c. List the individual from whom legal custody was removed in the court order removing the child from the home.

Question 4d. If this is the same person listed in 4a, indicate "Yes". If the answer is no, determine if the child lived with the person listed in 4c within the 6 months prior to the removal from the home. If the child lived with the individual within the 6 months, list the month(s) that the child lived with the person. List all individuals living in the home at the time the child was removed.

Question 5 is self-explanatory. If disability/incapacity or unemployed parent is indicated, additional information may be needed by the Rev Max MES to determine eligibility.

Question 6 is self-explanatory.

Question 7 is self-explanatory. The SSCM/JPPS's statement is accepted if in writing, signed and dated by the SSCM/JPPS.

This section of the form must be signed and dated by the SSCM/JPPS. Please print name and provide a contact phone number with area code.

Distribution

File the original form in the case record and fax a copy to Revenue Maximization Intake Unit at 770-473-2620 for Medicaid application. Fax the completed IV-E Information to the appropriate Revenue Maximization Regional Office.

Form 224 Removal Home Income and Asset Checklist

224i Instructions for Form 224: Removal Home - Income and Asset Checklist

Purpose

This form is to be completed by the SSCM/JPPS for all foster care and adoption assistance applications forwarded to the appropriate Revenue Maximization Regional Office. The function of the form is to provide all necessary information for the Rev Max MES to determine financial eligibility in the removal home and is a part of the application for Medicaid and IV-E Foster Care and Adoption Assistance, Form 223.

Indicate on this form if the information provided is for the month of application or for a prior month's MAO and indicate the month. If Medicaid is being requested for any of the three months prior to the application month, complete a separate Form 224 for the application month and for each month of retroactive MAO requested.

Instructions

This form should be completed for everyone that lived in the removal home. Each block must be completed with an amount or n/a. Drawn lines through this form are not acceptable. The Rev Max MES may request additional information for a member of the removal home if needed for the eligibility determination.

Income Section: Each block should be completed by the SSCM/JPPS. Each income source has a brief description. Some descriptions request additional information be provided. If no income exists for the source, enter N/A. If there is income from the source, list the monthly amount prior to any withholding. In the "recipients" column, list the name of the person to whom the income belongs. List employer, address, and phone number if available.

Resources Section: This section should be completed in the same manner as the income section. In the Household Management Section, note whether any vehicle is used as a home or as a means of income (example: delivery of newspapers, taxi), transportation to and from work and indicate if any money is owed on the vehicle.

Household Management:

A family with no source of income is managing to survive. Indicate what they are doing to survive (living in a shelter, visiting soup kitchens, prostituting, drug dealing, any other illegal form of employment, family providing room and board, etc.).

The form should be signed and dated by the SSCM/JPPS with a printed name and telephone number.

Distribution

The original should be retained in the case record with a copy faxed to the appropriate Revenue Maximization Regional Office.

Revision Date: 12/04

Form 225 IV-E Eligibility Documentation Sheet

Form 226 Medicaid and IV-E Redetermination

226i Instructions for Form 226: Medicaid and IV-E Redetermination Form

Purpose

Notification from the MES to the SSCM that a redetermination is due and information is needed.

Instructions

The top section or header information which includes the name, date of birth, date child entered care, current placement, child's AU number, child's SUCCESS Medicaid number, and the month review is due should be completed by the MES before the form is sent to the SSCM.

Questions 1 thru **5**, and **8** are self explanatory, and should be answered by the SSCM.

Question 6: If disabled/incapacitated is circled and the parent(s) is not receiving SSI or RSDI, then updated medical information may be required.
If unemployed is circled and/or the previous determination was based on unemployed parent criteria, current information should be made available by the SSCM concerning the employment of the parent(s). This information would include monthly gross income and place of employment.

Question 7: List any income that is received by the foster child (examples: RSDI and child support). This includes any income that belongs to the child.

Question 8: If current placement is different from the placement information in the top section, please give new placement information. Also, indicate if placement is in approval status. If the current placement is different from the placement appearing at the top of Form 226, have there been placements that occurred between the placement listed at the top and the current placement? If the answer is yes, the name and address of each placement(s), the dates of placement, and whether or not the placement was an approved placement should be listed.

The form should be signed by the JPPS/SSCM with a printed name and current telephone number. The original form should be retained in the social services case record and a copy should be faxed to the MES at the appropriate Revenue Maximization Regional Office.

Revision Date: 07/05

Form 227 Notification of Change in Foster Care or Adoption Assistance

227i Instructions for Form 227: Notification of Change in Foster Care or Adoption Assistance

Purpose

Form 227 is to be completed by the Social Services Case Manager (SSCM) / Juvenile Probation Parole Specialist (JPPS) to address **any and all** changes or **to provide additional information** that may potentially affect the eligibility and/or reimbursability for IV-E Foster Care or Adoption Assistance, Child Welfare (IV-B) Foster Care, State Adoption Assistance, or the Medicaid status of a child in placement, a child moving to a relative placement, a child "aging out" of foster care and/or DFCS relieved of legal custody.

The checkbox at the top of the form is to ensure that placement changes are processed timely and a Form 529 is generated to pay foster parents timely.

Instructions

This form is completed for any changes in the court order, court order not received within 60 days, timing of hearings, lapsed or expired custody, foster care placement, adoption assistance, parental deprivation, the child's income or resources, age, legal responsibility, VPA (Voluntary Placement Agreement), trial home visit, DFCS relieved of custody of a child or a child moving to a relative placement.

There are special situations that may potentially affect a child's eligibility and/or reimbursability and are communicated to the Revenue Maximization MES for case documentation and review. These special situations may include but are not limited to: a change to a non IV-E reimbursable placement, length of time on run-away status, a IV-E minor giving birth, a Georgia IV-E child placed out-of-state, a child approved for Supplemental Security Income (SSI), a decision regarding receipt of SSI or IV-E payments, INS verification child does/does not have qualified alien status, or any other circumstances that are considered special situations. Special situations are addressed in the "Comments" section of this form. If additional space is needed, continue on a separate sheet.

Complete the appropriate item(s) indicating a change or additional information. All information requested for each item should be entered. Provide the effective date where applicable.

The completed form should be faxed or sent as a Word attachment to the Revenue Maximization Regional Office or to DJJ MES to provide timely notice of a change.

Living Arrangement Section:

All information requested on the form will be provided by the SSCM/JPPS in order to determine ongoing Medicaid eligibility for foster children moving to a relative placement (including a parent) and for foster children leaving foster care due to age and where DFCS has been relieved of custody.

Comment Section:

Any additional comments or explanation should be entered in the comments section.

The comment section should also be used by the SSCM/JPPS to notify the MES of concurrent placement information. (Refer to Section 2860-2). If additional space is needed, continue on a separate sheet.

The form must be signed by the SSCM or JPPS and the caseload number, county, telephone number and printed name provided in the appropriate spaces.

Distribution

The original should be filed in the Social Services record and a copy should be faxed to the appropriate Revenue Maximization Regional Office.

Form 238 Medically Needy Budget Sheet

Form 239M MAGI Budget Sheet

285i Instructions for Form DMA-285: Third Party Liability Health Insurance Information Questionnaire

1. LEGIBLY PRINT information in every applicable field on the form.
2. If the DMA-285 is for a legal action, Trust or QIT, write “Legal Action”, “TRUST” or “QIT” in red ink at the top of the form.
3. If this form is completed to report a change, personal reimbursement, death or cancellation of an insurance policy, write “Change”, “Cancellation”, “Death”, “Reimbursement”, etc. in red ink at the top of the form. You may use a copy of the original 285 sent to DMA if it is legible.
    - If you have a letter confirming cancellation of the policy, attach the letter to the 285.
    - If the A/R has never had the insurance or if it was cancelled several years ago, attach to a 285 a copy of the MHN screen showing the insurance and annotate that the A/R has never had or has not had the insurance in years.
    - If you are reporting the death of an A/R who has a QIT, also write the date of death next to “Death” as MM/DD/YY.
    - If the A/R has personally been reimbursed for a service covered by Medicaid or has received a settlement from a pending legal action, mail/fax a copy of the existing 285 and attach a copy of the Explanation of Benefits (EOB) or letter outlining the settlement that accompanies the check. Attach a copy of the check, if available.
4. Do not submit this form if the only health insurance the A/R(s) have is Medicare or Medicaid.
5. Complete the name and address, etc. of the head of household in the AU as entered in SUCCESS.
6. Check whether the case is for an application or redetermination.
7. If you plan to send this form to DMA for an active policy, trust, etc., check “Yes” to having a private, group or government health insurance…..
8. Check yes or no as appropriate if someone else has health insurance on the A/R(s).
9. Check the appropriate type of policy that exists for the A/R(s). Attach a copy of the front and back of the health insurance card, if possible.
10. If the form is for a trust or QIT, cross out “Policy Holder” and write in “Trustee”. Enter the name of the policy holder or trustee.
11. Enter the address of the policy holder or trustee as appropriate.
12. Enter the policy holder’s SSN.
13. Enter the phone number of the policy holder or trustee.
14. Enter the name address, policy number and effective date in the appropriate fields. If insurance is cancelled, write “Cancelled” above “Effective Date” and the date cancelled in the space available.
15. If the insurance policy is through an employer, enter the information pertaining to the employment in the spaces provided.
16. List the names of the household members who are Medicaid A/Rs covered under the insurance policy. Enter their relationship to the A/R given as the “Case Name” at the top of the form. If it’s the same write “Self”. Provide the date of birth. Enter the SUCCESS ID #. Enter the SSN of the

individual.

17. If possible, have the A/R or PR sign the document in the two spaces provided.
18. The worker should LEGIBLY PRINT his/her name, DIRECT phone number and DFCS county.
19. See Section 2230 for mailing/faxing instructions.

PCG, the entity charged with handling DMA-285, has a 30 day standard of promptness. If it is necessary to have an immediate correction made concerning a TPR, fax the information to PCG rather than mailing. At times MHN may show insurance coverage that the MES is not aware of. Always double check with the A/R before assuming that the insurance shown is not valid. However, a pharmacy should never deny a member their prescriptions because of TPR issues. They have override codes to enter to make the prescription claim be accepted.

Form 297 Application for TANF, Food Stamps or Medical Assistance

Form 297 LP Application for TANF, Food Stamps or Medical Assistance (Large Print)

Form 297 SP Application for TANF, Food Stamps or Medical Assistance (Spanish)

Form 297 SP LP Application for TANF, Food Stamps or Medical Assistance (Spanish) (Large Print)

Form 297A Rights & Responsibilities

Welcome to the Georgia Division of Family and Children Services!

If you need help reading or completing this document or need help communicating with us, ask us or call (877) 423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

Community Outreach Services

For more information about other DHS services, please visit our website at dfcs.georgia.gov or call (877) 423-4746.

We are giving you this information to help you understand your rights and responsibilities when you receive help for Food Assistance, Cash Assistance and Medical Assistance. Please read over the Rights and Responsibilities for the programs in which you are applying and sign the signature page. If you are applying for someone else, these rights and responsibilities apply to that person as well.

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.

What Are My Rights in the Food Stamp (SNAP), TANF and Medicaid Programs?

In all programs, you have the right to:

- **request assistance filling out this form and free language assistance services** (interpreters, translated materials, or direct in-language services) if you have trouble reading, writing, speaking, or understanding the English language.
- **request auxiliary aids and services and reasonable modifications** if you or someone in your household has a disability.
- **request a fair hearing in writing or in person**. You have the right to be represented by a household member, legal counsel, a relative, a friend or other spokesperson.

If you are not satisfied with the action we have taken on your case, you can request a hearing by contacting the county office where you applied for benefits, by calling (877) 423-4746, or uploading a written request at www.gateway.ga.gov.

- **review some of the material and information in your case file**. However, you may not be able to see all of the information in the case file, such as names of people who have given us information about you or your household members or information about any criminal prosecutions involving you or any of your household members.
- **decide if you want to provide Social Security Number (SSN), citizenship, or immigration status information.** To qualify for public assistance, individuals must be a U.S. citizen, U.S.

National, or eligible immigrant. Pursuant to 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, DFCS is authorized to request your and your household members SSN.

Individuals who are applying for public assistance must provide or apply for an SSN, and/or verify their citizenship or immigration status, if we are unable to verify through electronic data sources. Some immigrants are eligible, and some are not, depending on their legal status. For Medicaid, depending on their immigration status, some immigrants may be eligible for full Medicaid benefits or Emergency Medical Assistance (EMA) benefits. If you or anyone in your household does not have an SSN, we can help you apply for one.

Applying for an SSN will not delay a decision on your application for benefits. If you are applying for emergency medical services only, you do not have to provide your SSN or information about your immigration status. EMA, including labor and delivery, is available for pregnant non-qualified and undocumented immigrants.

An individual, who is not applying for public assistance and who does not provide an SSN, citizenship or immigrant status may be designated as a non-applicant. A non-applicant is **not** required to provide an SSN, citizenship, or immigrant status but is required to provide other information that may affect the eligibility of other applicant household members such as income or resources.

A non-applicant is not eligible to receive benefits.

Only the people who give information to us about their SSN, citizenship, or immigration status will be eligible to receive benefits. We will use this information to check the Income and Eligibility Verification System (IEVS). We will also match your information with other Federal, state, and local agencies to verify your income and eligibility, wage information and work activities. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a Food Stamp (SNAP) claim, the information on this application, including SSNs, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim.

We will not share your information with the United States Citizenship and Immigration Services (USCIS); however, if immigration status information has been submitted on your application, this information may be subject to verification through USCIS and may affect your household's eligibility and benefit level.

We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status. Applying for or receiving **Food Stamp (SNAP) benefits does not** make a non-citizen a public charge.

Receiving or accepting **Supplemental Security Income (SSI), TANF cash assistance, Institutionalized Long-Term Care Medicaid, or state General Assistance could make** a non-citizen a public charge if all eligibility criteria are met. However, receiving these benefits does not automatically make an individual inadmissible or ineligible to adjust his/her status to lawful permanent resident on a public charge basis. A "public charge" means you are a person who is likely to become "primarily dependent" on the government to maintain your way of life, as demonstrated by either the receipt of public cash assistance for income maintenance or by institutionalization for long-term care at the government's expense."

If you are considered to be a public charge, you will not be deported, or denied permanent status because you have applied for or receive public assistance.

- **decide if you want to provide information about your race and ethnicity**. We collect data on race and ethnicity to ensure we are in compliance with Federal civil rights laws. By providing this 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.

What Are My Responsibilities in the Food Stamp (SNAP), TANF and Medicaid Programs?

In all programs, you are responsible for:

- giving your worker correct information and providing proof of statements needed to receive benefits. When you sign this form, you are giving your worker permission to get information from your employer, bank, neighbor, or others so we can make sure you are receiving the correct amount of benefits.
- telling the truth at all times. If you or someone who is applying for you provides incorrect information, you may lose your benefits or be subject to criminal prosecution for knowingly providing false information.
- providing proof that you or anyone in your household applying for benefits is a U.S. Citizen, U.S. National or qualified immigrant.

> Your worker will give you a list of ways you can prove your citizenship or immigration status if they are unable to verify through electronic data sources. For Medicaid, if you are not a U.S. Citizen, U.S. National or qualified immigrant, you may qualify for emergency coverage, and an individual without qualifying status will not be required to provide proof of status.

- reporting certain changes in your household situation. Each program has different reporting requirements. See the responsibilities section for each program for things you need to report.

What Other Responsibilities Do I Have in the Food Stamp (SNAP) Program?

In the Food Stamp (SNAP) Program, you are also responsible for:

- cooperating with Quality Control reviewers when they call or come to your home to interview you about the information you have given your case manager. If you do not cooperate with them, your case may be denied or closed.
- repaying benefits you should not have received.
- reporting when your household's total gross monthly income is more than 130% of the Federal Poverty Level for the household size. If you are a working adult with no children, you must report when your work hours fall below 20 hours per week or 80 hours per month. You must report these changes within 10 days from the end of the month in which the increase or change occurred. You may be given a Notice of Simplified Reporting Requirements, which explains more about this requirement.

- reporting when your household receives substantial lottery and gambling winnings. This is a cash prize won in a single game. If you or a household member receives lottery or gambling winnings, gross amount of $4250 or more (before taxes or other amounts are withheld), you must report these winnings within 10 days from the end of the month in which the household member received the winnings.

Food Stamp (SNAP) households **CAN NOT** use their benefits to purchase non-food items such as beer, wine, liquor, cigarettes, tobacco, pet foods, soaps, paper products and household supplies.

Food Stamp (SNAP) households also **ARE NOT** allowed to purchase food on credit with their benefits.

Food Stamp (SNAP) households **CAN NOT** give false information or hide information to get benefits that their household should not get.

Food Stamp (SNAP) households **CAN NOT** use Food Stamps (SNAP) or EBT cards that are not theirs and should not let someone else use their card.

Food Stamp (SNAP) households **CAN NOT** trade or sell Food Stamps (SNAP) or EBT cards for illegal items such as firearms, ammunition, or a controlled substance (illegal drugs).

What Are My Rights and Responsibilities for Reporting Household Expenses in the Food Stamp (SNAP) Program?

In the Food Stamp (SNAP) Program, certain household expenses such as shelter costs, medical bills, dependent care costs, and child support paid outside the home may affect the amount of benefits you receive.

If you have heating or cooling expenses, you may be eligible to receive the standard utility allowance.

If you have only **one** utility expense and it is NOT a heating or cooling expense, you may be eligible to receive a deduction for the actual expense incurred.

If you have only one telephone expense and no heating or cooling expenses, you may be eligible to receive the standard telephone allowance. If you want us to consider these expenses, you are responsible for reporting and verifying them. If you fail to report or verify actual utility expenses, we will not use them to determine your benefit amount.

What Are the Penalties in the Food Stamp (SNAP) Program?

The Food Stamp (SNAP) Program penalties are provided in the chart below.

Intentional Program Violations

If you or any household member	You will be INELIGIBLE
• hides information or does not tell the truth; • uses EBT cards that belong to someone else; • uses FS benefits to buy alcohol or tobacco, trades or sells FS benefits or EBT cards	• for **12 months** for the first offense, • **24 months** for the second offense, • and **permanently** for the third offense.

If you or any household member	You will be INELIGIBLE
• has used or received FS benefits in a transaction involving the sale of a controlled substance	• for **24 months** for the first offense and • **permanently** for the second offense.
• has used or received FS benefits in a transaction involving the sale of firearms, ammunition, or explosives after 8/22/1996	• **permanently** for the first offense.
• has been convicted for trafficking benefits for an amount of $500 or more after 8/22/1996	• **permanently** for the first offense.
• has a felony conviction because of behavior related to the possession, use or distribution of a controlled substance (drugs) after 8/22/1996	• until you are in compliance with the terms of probation or parole. • until you complete all the terms of probation or parole.
• has a felony conviction as an adult for aggravated sexual abuse, murder, sexual exploitation, and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such an offense after 2/7/2014	• until you are in compliance with the terms of probation or parole. • until you complete all the terms of probation or parole.
• is fleeing to avoid prosecution, custody, or confinement for a felony	• until you are no longer fleeing.
• is violating a condition of your probation or parole	• until you are no longer a probation or parole violator.
• has given false information about where you live or about your identity (who you are) to get multiple FS benefits in more than one area after 8/22/1996	• for **10 years.**

What Other Rights Do I Have in the TANF Program?

In the TANF Program, you have a right to:

- be excused from certain rules if you are a victim of domestic violence, sexual harassment, sexual assault, or stalking. Your case manager will talk to you about the rules that you will not have to follow.

What Other Responsibilities Do I Have in the TANF Program?

In the TANF Program, you are responsible for:

- cooperating with state and federal personnel who work for Fraud Prevention or the Office of Investigative Services and who are doing special case reviews. If you do not cooperate, your case may be denied or closed.
- repaying benefits you should not have received.
- participating in a work activity if you are a parent or an adult included in the TANF benefit, unless you are exempt. We will work with you to find the best work activities to help you become self-sufficient. We may have to reduce or stop your TANF benefits if you do not cooperate with us, and there is not a good reason.
- reporting that you or someone included in your TANF benefit has received or is expecting to receive a lump sum of money. Your TANF benefits may stop for one or more months, and your family may have to live on the lump sum for several months.

- cooperating with the Division of Child Support Services if you receive TANF benefits. You must help the Division of Child Support Services determine who is the father(s) of your child/children and help them get a court order for child support. If you do not cooperate with them and there is not a good reason, your TANF benefits may stop.
- notifying your case manager if you want to receive child support money instead of your TANF benefits. When you get TANF benefits, you may not receive all of your child support payment. You may receive only a portion of it called a “gap” payment. The state keeps the rest of the child support payment to pay back the TANF benefits that you receive.
- reporting certain changes in your household situation about you and other eligible household members within 10 days of knowing about them. Please let us know if you or any member of your household:
  - starts or stops receiving any unearned income
  - changes jobs, gets a new job, quits a job, or gets laid off
  - moves in or out of your home
  - has a baby or there is any other change
  - a child drops out of school
  - a child is absent from the home for a period of 45 consecutive days or longer
  - the whole family moves to another county or state, or,
  - someone dies

What Are the Penalties in the TANF Program?

In the TANF Program, there are penalties:

If you	You will lose TANF benefits
• hide information, do not report changes on time or do not tell the truth	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.
• hide information, do not report changes on time or do not tell the truth and are convicted in a court of law	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.
• give false information about where you live so you can receive benefits in more than one state and are convicted on or after 1/1/1997	• for 10 years.
• are convicted of other IPVs committed on or after 7/1/1998	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.
• Individuals convicted of an IPV for using cash assistance funds or the TANF EBT transactions performed at prohibited places on or after 6/1/2012	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.

If you	You will lose TANF benefits
• are convicted of a serious violent felony or a felony related to possession, use or distribution of a controlled substance on or after 1/1/1997	• permanently
• are fleeing to avoid prosecution, custody, or confinement for a felony	• and will be penalized until no longer fleeing to avoid prosecution, custody, or confinement
• are violating a condition of probation or parole	• and will be penalized until no longer a probation/parole violator

What Other Rights Do I Have in the Medicaid Program?

In the Medicaid Program, you have a right to:

- receive Medicaid even if you have other health insurance.
- choose your Medicaid doctor or provider. Always ask your doctors if they accept Medicaid as payment for their services.
- have your Medicaid application approved or denied within 10, 45 or 60 days from the date you apply, depending on the type of Medicaid.
- be excused from providing information about your children's absent parent or from pursuing medical support from the absent parent if you have a good reason such as domestic violence. Talk to your case manager if you think you have a good reason.

What Other Responsibilities Do I Have in the Medicaid Program?

In the Medicaid Program, you are also responsible for:

- telling your worker if you or your children have other health insurance. If the health insurance changes or ends, you must tell your worker within 10 days. The health insurance information is sent to the Department of Community Health. In most cases, your other health insurance must pay your medical expenses first. You must tell your doctor or other health care providers that you have other insurance so that they can bill the other health insurance providers before they bill Medicaid.
- cooperating with the Medicaid Estate Recovery Program if you are:
  - a resident in a nursing home
  - a resident in an intermediate care facility for individuals with intellectual disabilities
  - a resident in another medical institution where medical care is paid by Medicaid
- cooperating with the Medicaid Estate Recovery Program if you are age 55 years or older and:
  - receive home and community-based services.
  - are enrolled in and receive services through a waiver program.
- 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. (If you are completing this form 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 above as a condition of his/her eligibility for Medicaid).

- reporting changes about you and the other people in your Medicaid case. Please report:
- if you or other household members move
- if you or other household members change jobs, get a new job, quit a job, or get laid off.
- if you or other household members have a change in income or resources
- if a family member moves in or out of your home
- if you or another household member inherits or receives money or property from any source
- if someone in your home dies or gets married
- any other changes
- telling your case manager when your pregnancy ends. Pregnancy ends with the birth of the baby, a miscarriage, or an abortion. You must report the end of the pregnancy within 10 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 children will receive benefits unless good cause is established.
- cooperating with Medicaid Eligibility Quality Control when they call or come to your home to interview you about the information you have given your case manager.

Committing fraud or abuse is against the law. You may be referred to the Medicaid and PeachCare for Kids® Program Integrity Unit. Violators may be limited to using one provider, terminated from the program, or asked to reimburse the Department of Community Health for medical services provided.

Fraud is a dishonest act done on purpose. Abuse is an act that does not follow good practices.

Examples of Participant Fraud and Abuse

Examples of participant fraud and abuse are:

- Letting someone else use your Medicaid, PeachCare for Kids® or CMO health insurance card.
- Getting prescriptions with the intent of abusing or selling drugs
- Using forged documents to get services
- Misusing or abusing equipment that is provided by Medicaid or PeachCare for Kids®
- Providing incorrect information or allowing others to do so in order to obtain Medicaid or PeachCare for Kids® eligibility
- Failure to report changes which occur in income, living arrangements, or resources.

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

Peachtree Street NW, 5th Floor, Atlanta, GA 30303; or visit dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

Signature Page

I have received a copy of Form 297A, Rights and Responsibilities, for Benefits.

I certify, under penalty of perjury, all the information provided and everything I have told is the complete truth, as far as I know.

Signature Date

Authorized Representative / Witness / Responsible Person Date

Georgia Department of Human Services Division of Family and Children Services
Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Services and Third-Party Liability Requirements

Benefits of Child Support Services

Your help in the child support services process may be of value to you and your child because it may result in:

- Finding the absent parent.
- Legally establishing your child's paternity.
- Receipt of child support payments that may give you more money than if you receive Temporary Assistance for Needy Families (TANF).
- Acquisition of private health insurance through the absent parent.
- Acquisition of rights to future Social Security, veterans, or other government benefits.

Cooperation with DFCS and DCSS

The law requires you to help the Division of Family and Children Services (DFCS) and the Division of Child Support Services (DCSS) get any support owed to you and the children for whom TANF is requested, unless you have good cause for not helping.

In helping DFCS or DCSS, you must do one or more of the following:

- Name the absent parent(s) of any child for whom you are requesting TANF or Medicaid.
- Provide information to help find the absent parent(s).
- Help determine who the legal father is if your child was born out of wedlock.
- Agree to have a blood test if the person you name as the father denies paternity.
- Help the state get money owed to you and/or the child who receives TANF.
- Provide information about medical insurance the absent parent has on your child.

You must come to the DFCS office, DCSS or court to sign papers or provide needed information.

Good Cause

You may have good cause for not wanting to help DCSS collect child support or medical coverage for your child. You may not have to help if you believe helping is not in your child's best interest, and if you can prove it. If you want to claim good cause, you must tell your worker. You can do this at any time.

If You Do Not Help and Do Not Have Good Cause

- You will not be eligible to receive TANF for yourself and your child.
- Your child may still be eligible for Medicaid.

Good Cause Reasons

You may claim good cause for any of the following reasons:

- Your help may cause serious physical or emotional harm to your child or to you.
- The child was born as a result of rape or incest.
- Court proceedings are underway for adoption of the child.
- An agency is helping you to decide whether to place the child for adoption.

To Prove Good Cause, You Must

- give DFCS information it needs to decide if you have good cause for not helping. If you fear physical harm and cannot get proof, DFCS may still be able to make a good cause determination.
- give proof to DFCS within 20 days of claiming good cause. DFCS will give you more time only if you have trouble getting proof.

DFCS may excuse you from helping based on the information you provide. Or DFCS may ask you to provide more information. DFCS will not contact the absent parent without telling you.

If you are applying for TANF, you will not be approved until you give DFCS proof of your claim of good cause or the information DFCS needs to investigate your claim.

EXAMPLES OF PROOF OF GOOD CAUSE

- birth certificate, medical or law enforcement records showing that the child was born as a result of rape or incest
- court or other legal documents showing that adoption proceedings have begun
- court, medical, criminal, child protective services, social services, psychological or law enforcement records showing that the absent parent may hurt you or the child
- medical records or written statements from a mental health professional showing the history and current status of your and/or the child's emotional health
- a written statement from a public or private agency showing you are being helped to decide whether to give your child up for adoption
- sworn statements from friends, neighbors, clergy, social workers, or medical professionals who know why you have good cause.

If you need help in getting any of the documents, ask your worker.

Child Support Rules

If you receive TANF, you give the state of Georgia, by law, any rights you have to receive child support. Once the court order is established, the absent parent will be required to pay child support through DCSS. After the court order is established, you will be required to report any money you receive directly from the absent parent. You must also help establish paternity for your child and cooperate with DCSS in establishing a child support order. If you do not cooperate and do not have good cause, you may not be eligible for TANF.

If you receive TANF and the absent parent pays child support through the Division of Child Support Services (DCSS), you probably will NOT receive the full amount of the child support payment. Instead, you may receive a "gap" payment. All child support paid by an absent parent, which is in excess of the "gap" amount, is retained by DCSS and is used to pay back the TANF funds that you have received. ***Your TANF case manager can explain gap budgeting and the payment procedures to you.***

If your TANF case is closed, child support payments will be sent to you up to the amount of the absent parent's current monthly obligation. Any child support amount paid over the current obligation will be kept by the state to repay past TANF grants received by you. Once the past TANF grants are repaid, you will be sent all child support paid by the absent parent.

If your TANF case is closed and *then reopened, any child support back payments due you will be assigned to the state up to the* amount of all TANF money you have ever received. When the Unreimbursed Public Assistance (UPA) is repaid, then you will start receiving any back payments owed to you.

If you receive child support payments to which you are not entitled, you may have to repay the state. The state will notify you of the amount of the overpayment and the timeframe for repayment.

DCSS may review the DFCS good cause decision in your case. If you request a hearing about the decision, DCSS may participate in the hearing.

If you have good cause for not helping, DCSS will not try to establish paternity or collect child support.

I have read this notice about my rights to claim good cause and not helping to establish paternity or to collect child support from the absent parent.

Domestic Violence can happen to ANYONE.

- Domestic violence occurs on all social and economic levels, regardless of employment or education, race, or ethnic background, religion, marital status, physical ability, age, or sexual orientation.
- Each year more than 50,000 incidents of domestic violence are reported to Georgia Law Enforcement agencies.
- More than 50 percent of all women are battered by intimate partners at some time in their lives.
- A woman is physically abused every 9 seconds in this country, an estimated 2 to 4 million women annually.

- Battering is the leading cause of injury to women in the United States, more than rape, mugging or auto accidents combined.
- Nationally, 50 percent of all homeless women and children are on the streets because of violence in the home.
- Between 15 and 25 percent of pregnant women are battered.
- The Federal Bureau of Investigations (F.B.I). estimates that only 1 in 10 incidents of domestic violence are ever reported.
- Every day, 4 women in the United States, are murdered by their intimate partner.

FOR MORE INFORMATION

Free, confidential services are available from domestic violence shelter and programs supported by the Department of Human Services.

FOR HELP 24 HOURS A DAY, CALL (800) 334-2836

Call this toll-free number to speak to someone at your local domestic violence shelter. You can call from anywhere in the state to find a safe place to stay for you and your children and get other resources to help you.

What is Domestic Violence, Sexual Harassment, Sexual Assault, or Stalking?

- **Domestic violence** can include being hit, kicked, beaten, raped, choked, threatened, controlled, or kept from getting what you need to live (such as food, medicine, or a home) by a spouse, boyfriend, partner, or "ex."
- **Sexual harassment** is hostile, intimidating, or oppressive behavior based on sex that creates an offensive work environment.
- **Sexual assault** is nonconsensual sexual act proscribed by Federal, Tribal, or State law, including when the victim lacks capacity to consent.
- **Stalking** is the act or crime of willfully and repeatedly following or harassing another person in circumstances that would cause a reasonable person to fear injury or death especially because of express or implied threats.

Your local Department of Family and Children Services wants to help you and your children stay safe. If any of these things are happening to you, talk to your caseworker.

- Has your spouse, partner, boyfriend, or "ex" ever hit or slapped you?
- Has this person ever threatened to harm you?
- Has this person threatened to take your children?
- Does the person insult you or act jealous?
- Do you ever feel this person is running your life or keeping you away from your family and friends, or preventing you from going to work or school?
- Does the person keep track of what you do, where you go or who you talk to on the phone?
- Does the person destroy things you own or care about?
- Are you afraid of this person?

- Is it unsafe for you to go home?

If you answered YES to any of the questions, it may be time to think about safety for you and your children.

Domestic Violence and TANF

- Some of the requirements of Temporary Assistance for Needy Families (TANF) may not apply to you.
- You can tell a DFCS caseworker **anytime** that your partner is being violent.
- DFCS will refer you to someone you can talk to about your situation.
- DFCS will help you with assistance, a safe place to stay for you and your children, medical and mental health care, treatment for addiction and special help for victims of crime and domestic violence.
- DFCS will not share the information with anyone outside the agency without your knowledge.
- Let DFCS know when you are no longer in a dangerous situation.

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 dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form from the KB Team or online at 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 NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Ste. 150, Norcross, GA 30071, or PO 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, ADA/Section 504 complaint form. The complaint form is also available at 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 dch.georgia.gov/adasection-504-and-civil-rights.

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 "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.

Under the **Department of Community Health (DCH)** policy, the Medical Assistance programs cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or religion.

Do Not Send Applications to the USDA or HHS

Nondiscrimination Statement
In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS
USDA provides federal financial assistance for many food security and hunger reduction programs

such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail:** Food and Nutrition Service, USDA

1320 Braddock Place, Room 334, Alexandria, VA 22314; or

2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **phone:** (833) 620-1071; or
4. **email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or
email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

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 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746.

Do Not Send Applications to the USDA or HHS

Form 297A LP Rights & Responsibilities (Large Print)

Form 297A SP Rights & Responsibilities (Spanish)

¡Le damos la bienvenida a la División de Servicios para Familias y Niños de Georgia!

Si necesita ayuda para leer o completar este documento, o necesita ayuda para comunicarse con nosotros, pregúntenos o llame al (877) 423-4746. Nuestros servicios, incluidos los/as intérpretes, son gratuitos. Si es una persona sorda, con problemas de audición, sorda-ciega o tiene dificultades para hablar, puede llamarnos al número que figura anteriormente al marcar 711 (Retransmisión de Georgia).

Servicios de alcance comunitario
Para obtener más información sobre otros servicios del DHS, visite nuestro sitio web en http://dfcs.georgia.gov o llame al (877) 423-4746.

Nosotros le brindamos esta información para ayudarle a comprender sus derechos y responsabilidades cuando reciba ayuda para la Asistencia Alimentaria, Asistencia en Efectivo y Asistencia Médica. Lea los Derechos y Responsabilidades de los programas para los que está solicitando y firme la hoja de firmas. Si está solicitando para otra persona, estos derechos y responsabilidades también se aplican a esa 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.

¿Cuáles son mis derechos en los programas de cupones para alimentos (SNAP), TANF y Medicaid?

En todos los programas, tiene derecho a lo siguiente:

- **solicitar asistencia para completar este formulario y servicios gratuitos de asistencia con el idioma** (intérpretes, materiales traducidos o servicios directos en el idioma) si tiene problemas para leer, escribir, hablar o comprender el idioma inglés.
- **solicitar ayudas y servicios auxiliares y modificaciones razonables** si usted o alguien en su hogar tiene una discapacidad.
- **solicitar una audiencia imparcial por escrito o en persona**. Tiene el derecho a ser representado por un miembro del hogar, asesor legal, un pariente, amigo u otro vocero.

Si no está satisfecho con la acción que hemos tomado en su caso, puede solicitar una audiencia al comunicarse con la oficina del condado donde solicitó los beneficios o al llamar al (877) 423-4746, o al cargar una solicitud por escrito en www.gateway.ga.gov.

- **revisar parte del material y la información en el expediente de su caso**. Sin embargo, es posible que no pueda ver toda la información en el expediente del caso, como los nombres de las personas que nos han proporcionado información sobre usted o los miembros de su hogar, o

información sobre cualquier proceso penal que lo involucre a usted o a cualquiera de los miembros de su hogar.

- **decidir si desea proporcionar el número de seguro social (SSN, en inglés), ciudadanía, o información sobre el estado migratorio.** Para calificar para la asistencia pública, las personas deben ser ciudadanas estadounidenses, tener nacionalidad estadounidense, o ser inmigrantes elegibles. De conformidad con la Ley de Alimentos y Nutrición de 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, y

42 C.F.R. § 435.920, la DFCS está autorizada a solicitarle su SSN a usted y a los miembros de su hogar.

Las personas que están solicitando asistencia pública deben proporcionar o solicitar un SSN, o verificar su ciudadanía o estado migratorio, si no podemos verificarlo mediante fuentes de datos electrónicas. Algunas personas inmigrantes son elegibles y otras no, dependiendo de su estatus legal. Para Medicaid, dependiendo de su estado migratorio, algunas personas inmigrantes pueden ser elegibles para los beneficios completos de Medicaid o para los beneficios de Asistencia Médica de Emergencia (EMA). Si usted o alguien de su hogar no tiene un SSN, podemos ayudarle a solicitar uno.

Solicitar un SSN no demorará una decisión sobre su solicitud para obtener beneficios. Si está solicitando solamente servicios médicos de emergencia, no es necesario que proporcione su SSN o información acerca de su estado migratorio. La asistencia EMA, que incluye el trabajo de parto y el parto, está disponible para inmigrantes embarazadas no calificadas e indocumentadas.
Una persona que no está solicitando asistencia pública y que no proporcione un SSN, ciudadanía o estado migratorio puede ser designada como no solicitante. Una persona no solicitante no está obligada a proporcionar un SSN, ciudadanía, o estado migratorio pero está obligada a proporcionar otra información que pueda afectar la elegibilidad de otros miembros de la unidad familiar solicitantes, como ingresos o recursos.

Una persona no solicitante no es elegible para recibir beneficios.

Solo las personas que nos brinden información acerca de su SSN, ciudadanía, o estado migratorio serán elegibles para recibir beneficios. Usaremos esta información para verificar el Sistema de Verificación de Ingresos y Elegibilidad (IEVS, en inglés). También compararemos su información con otras agencias federales, estatales y locales para verificar sus ingresos y elegibilidad, información salarial y actividades laborales. Esta información también se puede dar a los oficiales de cuerpos policiales para que la utilicen para atrapar a las personas que huyen de la ley. Si su hogar tiene un reclamo de Cupones para Alimentos (SNAP), la información en esta solicitud, incluidos los SSN, se puede proporcionar a agencias federales y estatales y agencias privadas de cobro de reclamos para que la utilicen al cobrar el reclamo.

No compartiremos su información con los Servicios de Ciudadanía e Inmigración de los Estados Unidos (USCIS, en inglés); sin embargo, si ha enviado información sobre el estado migratorio en su solicitud, esta información puede estar sujeta a verificación a través del USCIS y puede afectar la elegibilidad y el nivel de beneficios de su hogar.

No denegaremos beneficios a otros miembros del hogar solicitantes porque otros miembros del hogar no proporcionen su SSN, ciudadanía, o estado migratorio. Solicitar o recibir beneficios de Cupones para Alimentos (SNAP) no convierte a una persona no ciudadana en una carga pública.

Recibir o aceptar **Ingresos de seguridad suplementarios (SSI, en inglés), TANF, asistencia en efectivo, Medicaid institucionalizado de atención a largo plazo, o Asistencia general estatal podría convertir** a una persona no ciudadana en una carga pública si se cumplen todos los criterios de elegibilidad. Sin embargo, recibir estos beneficios no hace automáticamente que una persona sea inadmisible o inelegible para ajustar su estado a residente permanente legal en función de la carga pública. Una "carga pública" significa que usted es una persona que es probable que se convierta en "principalmente dependiente" del gobierno para mantener su estilo de vida, como lo demuestra la recepción de asistencia pública en efectivo para el mantenimiento de los ingresos o la institucionalización a largo plazo a expensas del gobierno."

Si es considerado una carga pública, no será deportado, ni se le denegará el estatus permanente por haber solicitado o recibido asistencia pública.

- **Decida si desea proporcionar información sobre su raza y etnia**. Recopilamos datos sobre la raza y etnia para asegurarnos de que cumplimos con las leyes federales de derechos civiles. Al proporcionar esta información, nos ayudará a administrar nuestros programas de manera no discriminatoria. Su hogar no está obligado a proporcionarnos esta información y no afectará su nivel de elegibilidad o de beneficios.

¿Cuáles son mis responsabilidades en los programas de cupones para alimentos (SNAP), TANF y Medicaid?

En todos los programas, usted es responsable de lo siguiente:

- dar al administrador de su caso la información correcta y proporcionar prueba de las declaraciones necesarias para recibir los beneficios. Cuando firma este formulario, está dando al administrador de su caso permiso para obtener información de su empleador, banco, vecino u otros para que podamos asegurarnos de que está recibiendo la cantidad correcta de beneficios.
- decir la verdad en todo momento. Si usted o alguien que solicita por usted proporciona información incorrecta, puede perder sus beneficios o estar sujeto a un proceso penal por proporcionar información falsa a sabiendas.
- proporcionar pruebas de que usted o cualquier persona de su hogar que solicite beneficios es una persona ciudadana estadounidense, nacional estadounidense, o inmigrante calificada. **Aviso:** El administrador de su caso le proporcionará una lista de las formas en las que puede probar su ciudadanía o estado migratorio si no puede verificarlo mediante fuentes de datos electrónicas. Para Medicaid, si no es una persona ciudadana estadounidense, nacional estadounidense, o inmigrante calificada, puede calificar para recibir una cobertura de emergencia, y no se requerirá que una persona sin estado calificado proporcione prueba del estado.
- informar ciertos cambios en la situación de su hogar. Cada programa tiene diferentes requisitos de presentación de informes. Consulte la sección de responsabilidades para cada programa para conocer los aspectos que debe informar.

¿Qué otras responsabilidades tengo en el programa de cupones para alimentos (SNAP)?

En el Programa de Cupones para Alimentos (SNAP), también es responsable de lo siguiente:

- cooperar con los revisores de control de calidad cuando llamen o vayan a su hogar para entrevistarlo sobre la información que le ha dado a su administrador de casos. Si no coopera con ellos, su caso puede ser denegado o cerrado.
- reembolsar beneficios que no debería haber recibido.
- informar cuando el ingreso mensual bruto total de su hogar es más del 130% del Nivel Federal de Pobreza para el tamaño del hogar. Si es un adulto que trabaja sin hijos, debe informar cuando sus horas de trabajo disminuyan a menos de 20 horas por semana o 80 horas por mes. Debe informar estos cambios dentro de los 10 días posteriores al final del mes en el que ocurrió el aumento o cambio. Es posible que reciba un Aviso de requisitos de presentación de informes simplificados, que explica más sobre este requisito.
- informar cuándo su hogar recibe ganancias sustanciales de lotería y juegos de azar. Esto se refiere a un premio de dinero en efectivo ganado en un solo juego. Si usted o un miembro del hogar recibe ganancias de lotería o juegos de azar, un monto bruto de $4250 o más (antes de que se retengan los impuestos u otros montos), debe informar estas ganancias dentro de los 10 días posteriores al final del mes en el que el miembro del hogar recibió las ganancias.

Los hogares con cupones para alimentos (SNAP) **NO** PUEDEN **usar sus beneficios** para comprar artículos no alimentarios tales como cerveza, vino, licor, cigarrillos, tabaco, alimento para mascotas, jabones, productos de papel y artículos para el hogar.

Los hogares con cupones para alimentos (SNAP) TAMPOCO PUEDEN comprar alimentos a crédito con sus beneficios.

Los hogares con cupones para alimentos (SNAP) **NO** PUEDEN dar información falsa u ocultar información para obtener beneficios que su hogar no debería recibir.

Los hogares con cupones para alimentos (SNAP) **NO** PUEDEN **usar Cupones** para Alimentos (SNAP) o tarjetas EBT que no sean suyas y no deben permitir que otra persona use su tarjeta.

Los hogares con cupones para alimentos (SNAP) **NO** PUEDEN intercambiar ni vender Cupones para Alimentos (SNAP) o tarjetas EBT por artículos ilegales tales como armas de fuego, municiones, o una sustancia controlada (drogas ilegales).

¿Cuáles son mis derechos y responsabilidades para informar los gastos del hogar en el programa de cupones para alimentos (SNAP)?

En el programa de cupones para alimentos (SNAP), algunos gastos del hogar tales como los costos de vivienda, facturas médicas, costos de cuidado de dependientes, y manutención infantil pagados fuera del hogar pueden afectar la cantidad de beneficios que recibe.

Si tiene gastos de calefacción o refrigeración puede ser elegible para recibir la asignación estándar de servicios públicos.

Si sólo tiene un gasto de servicio público y NO es un gasto de calefacción o refrigeración, puede ser elegible para recibir una deducción por el gasto real incurrido.

Si tiene solamente un gasto de teléfono y no tiene gastos de calefacción o refrigeración puede ser elegible para recibir la asignación estándar de teléfono. Si desea que consideremos estos gastos, es

responsable de informarlos y verificarlos. Si no informa o verifica sus gastos reales de servicios públicos, no los usaremos para determinar el monto de su beneficio.

¿Cuáles son las sanciones del programa de cupones para alimentos (SNAP)?

Las sanciones del programa de cupones para alimentos (SNAP) se proporcionan en la tabla a continuación.

Infracciones intencionales del programa

Si usted o algún miembro de su hogar…	Será INELEGIBLE
• oculta información o no dice la verdad; • utiliza tarjetas EBT que pertenecen a otra persona; • utiliza los beneficios de cupones para alimentos para comprar alcohol o tabaco, intercambia o vende beneficios de cupones para alimentos o tarjetas EBT	• por **12 meses** por la primera infracción, • **24 meses** por la segunda infracción, • y **permanentemente** por la tercera infracción.
• ha utilizado o recibido beneficios de cupones para alimentos en una transacción que involucre la venta de una sustancia controlada	• por **24 meses** por la primera infracción y • **permanentemente** por la segunda infracción,
• ha utilizado o recibido beneficios de cupones para alimentos en una transacción que involucre la venta de armas de fuego, municiones o explosivos luego del 22/8/1996	• **permanentemente** por la primera infracción.
• tiene una condena por tráfico de beneficios por un monto de $500 o más luego del 22/8/1996	• **permanentemente** por la primera infracción.
• tiene una condena por comportamiento relacionado con la posesión, uso o distribución de una sustancia controlada (drogas) luego del 22/8/1996	• hasta que cumpla con los términos del período de prueba o libertad condicional. • hasta que complete <u>todos</u> los términos del período de prueba o libertad condicional.
• tiene una condena por delito grave como adulto por abuso sexual agravado, asesinato, explotación sexual y otros abusos de niños, un delito federal o estatal que involucre agresión sexual, o un delito según la ley estatal que el Fiscal General determine que es sustancialmente similar a tal ofensa después del 7/2/2014	• hasta que cumpla con los términos del período de prueba o libertad condicional. • hasta que complete <u>todos</u> los términos del período de prueba o libertad condicional.
• está huyendo para evitar enjuiciamiento, custodia, o confinamiento por un delito grave	• hasta que ya no huya.
• está infringiendo una condición de su período de prueba o libertad condicional	• hasta que ya no infrinja el período de prueba o libertad condicional.
• ha proporcionado información falsa sobre el lugar donde vive o sobre su identidad (quien es) para obtener múltiples beneficios de cupones para alimentos en más de un área luego del 22/8/1996	• por **10 años.**

¿Qué otros derechos tengo en el programa TANF?

En el programa TANF, tiene derecho a lo siguiente:

- ser eximido de ciertas reglas si es víctima de violencia doméstica, acoso sexual, agresión sexual o acoso. El administrador de su caso le hablará sobre las reglas que no tendrá que seguir.

¿Qué otras responsabilidades tengo en el programa TANF?

En el programa TANF, usted es responsable de lo siguiente:

- cooperar con el personal estatal y federal que trabaja en Prevención de Fraude o la Oficina de Servicios de Investigación y que está haciendo revisiones de casos especiales. Si no coopera con ellos, su caso puede ser denegado o cerrado.
- reembolsar beneficios que no debería haber recibido.
- participar en una actividad laboral si es un/a padre/madre o adulto/a incluido en el beneficio TANF, a menos que esté exento. Trabajaremos con usted para encontrar las mejores actividades laborales para ayudarlo a ser autosuficiente. Es posible que tengamos que reducir o suspender sus beneficios TANF si no coopera con nosotros, y no hay una razón justificada.
- informar que usted o alguien incluido en su beneficio TANF ha recibido o espera recibir una suma global de dinero. Es posible que sus beneficios TANF cesen por uno o más meses y su familia deba vivir de la suma global durante varios meses.
- cooperar con la División de Servicios de Manutención Infantil si recibe beneficios TANF. Debe ayudar a la División de Servicios de Manutención Infantil a determinar quién es el/los padre/s de su/s hijo/s y ayudarlos a obtener una orden judicial de manutención infantil. Es posible que tengamos que reducir o suspender sus beneficios TANF si no coopera con nosotros, y no hay una razón justificada.
- notificar a su administrador de casos si desea recibir dinero de manutención infantil en lugar de sus beneficios TANF. Cuando reciba beneficios TANF, puede que no reciba todo el pago de manutención infantil. Es posible que reciba solo una parte del mismo, lo que se denomina pago de “brecha”. El estado se queda con el resto del pago de manutención infantil para devolver los beneficios TANF que recibe.
- informar ciertos cambios en la situación de su hogar sobre usted y otros miembros elegibles de su hogar dentro de los 10 días de haberlos sabido. Háganos saber si usted o algún miembro de su hogar:
  - comienza o deja de recibir ingresos no derivados del trabajo
  - cambia de trabajo, obtiene un nuevo trabajo, renuncia a un trabajo o es despedido
  - se muda a o de su hogar
  - tiene un bebé o hay algún otro cambio,
  - un niño abandona la escuela
  - un niño se ausenta del hogar por un período de 45 días consecutivos o más
  - toda la familia se muda a otro país o estado, o,
  - alguien fallece

¿Cuáles son las sanciones en el programa TANF?

En el programa TANF, existen sanciones:

Si usted …	Perderá los beneficios de TANF …

• esconde información, no informa cambios a tiempo o no dice la verdad	• por 6 meses por la primera infracción, • por 12 meses por la segunda infracción, • y permanentemente por la tercera infracción.
• esconde información, no informa cambios a tiempo o no dice la verdad y es condenado en un tribunal de justicia	• por 6 meses por la primera infracción, • por 12 meses por la segunda infracción, • y permanentemente por la tercera infracción.
• da información falsa sobre el lugar donde vive para poder recibir beneficios en más de un estado y es condenado a partir del 1/1/1997	• por 10 años.
• es condenado por otras infracciones intencionales al programa (IPV) cometidas a partir del 1/7/1998	• por 6 meses por la primera infracción, • por 12 meses por la segunda infracción, • y permanentemente por la tercera infracción.
• Personas condenadas por una IPV por utilizar fondos de asistencia en efectivo o las transacciones EBT de TANF realizadas en lugares prohibidos a partir del 1/6/2012	• por 6 meses por la primera infracción, • por 12 meses por la segunda infracción, • y permanentemente por la tercera infracción.
• es condenado por un delito grave violento o un delito grave relacionado con la posesión, el uso o la distribución de una sustancia controlada a partir del 1/1/1997	• permanentemente
• está huyendo para evitar enjuiciamiento, custodia, o confinamiento por un delito grave	• y será sancionado hasta que ya no huya para evitar el enjuiciamiento, la custodia o el confinamiento
• está infringiendo una condición de su período de prueba o libertad condicional	• y será sancionado hasta que ya no sea un infractor del período de prueba/libertad condicional

¿Qué otros derechos tengo en el programa Medicaid?

En el programa Medicaid, tiene derecho a lo siguiente:

- recibir Medicaid aún si tiene otro seguro médico.
- elegir su médico o proveedor de Medicaid. Pregunte siempre a sus médicos si aceptan Medicaid como pago por sus servicios.
- tener su solicitud de Medicaid aprobada o denegada dentro de 10, 45 o 60 días a partir de la fecha de su solicitud, dependiendo del tipo de Medicaid.
- estar exento de proporcionar información sobre el padre ausente de sus hijos o de buscar apoyo médico del padre ausente si tiene una razón justificada, tal como violencia doméstica. Hable con su administrador de casos si cree que tiene una razón justificada.

¿Qué otras responsabilidades tengo en el programa Medicaid?

En el programa Medicaid, también es responsable de lo siguiente:

- decirle al administrador de su caso si usted o sus hijos tienen otro seguro de salud. Si el seguro de salud cambia o es suspendido, debe comunicarlo al administrador de su caso dentro de los 10 días. La información del seguro de salud se envía al Departamento de Salud Comunitaria. En la mayoría de los casos, su otro seguro médico debe pagar primero sus gastos médicos. Debe informar a su médico u otros proveedores de atención médica que tiene otro seguro para que

puedan facturar a los otros proveedores de seguro médico antes de facturarle a Medicaid.

- cooperar con el programa de Medicaid de Recuperación Patrimonial si usted es:
  - un residente en un hogar de ancianos
  - un residente en un centro de atención intermedia para personas con discapacidad intelectual
  - un residente en otra institución médica donde la atención médica es pagada por Medicaid
- cooperar con el programa de Medicaid de Recuperación Patrimonial si usted tiene 55 años o más y:
  - recibe servicios en el hogar y basados en la comunidad.
  - está inscripto y recibe servicios a través de un programa de exención.
- Acepto ceder al estado todos los derechos a la manutención médica y al pago de la atención médica de cualquier tercero (hospital y beneficios médicos). Acepto cooperar con el estado para identificar y proporcionar información para ayudar al estado en la búsqueda de cualquier tercero que pueda ser responsable de pagar por la atención y los servicios. Entiendo que debo informar cualquier pago recibido por atención médica dentro de los diez días. (Si está completando este formulario en nombre de otra persona y no tiene el poder para ejecutar una asignación para esa persona, ésta deberá ejecutar una asignación de los derechos descriptos anteriormente como condición de su elegibilidad para Medicaid).
- informar cambios sobre usted y las otras personas en su caso de Medicaid. Le solicitamos que informe:
- si usted u otros miembros del hogar se mudan
- si usted u otros miembros del hogar cambian de trabajo, obtienen un nuevo trabajo, renuncian a un trabajo o son despedidos.
- si usted u otro miembro del hogar tienen un cambio en los ingresos o recursos
- si un miembro de la familia se muda de o a su hogar
- si usted u otro miembro del hogar hereda o recibe dinero o propiedad de cualquier fuente
- si alguien en su hogar fallece o se casa
- cualquier otro cambio
  - informarle al administrador de su caso cuando termina su embarazo. El embarazo termina con el nacimiento del bebé, un aborto espontáneo, o un aborto. Debe informar el fin del embarazo dentro de los 10 días.
  - Acepto dar al estado el derecho de requerir que un padre ausente proporcione seguro médico, si está disponible. Entiendo que debo obtener apoyo médico del padre ausente si está disponible y debo cooperar con la División de Servicios de Manutención Infantil para obtener este apoyo. Si **no** coopero, entiendo que puedo perder mis beneficios de Medicaid y solamente mis hijos recibirán beneficios a menos que se establezca una razón justificada.
  - cooperar con los revisores de control de calidad de elegibilidad de Medicaid cuando llamen o vayan a su hogar para entrevistarlo sobre la información que le ha dado a su administrador de casos.

Cometer fraude o abuso va en contra de la ley. Es posible que lo deriven a la Unidad de Integridad

del programa de Medicaid y PeachCare for Kids®. Los infractores pueden limitarse a utilizar un solo proveedor, ser despedidos del programa o ser requeridos a reembolsar al Departamento de Salud Comunitaria por los servicios médicos proporcionados..

El fraude es un acto deshonesto cometido a propósito. El abuso es un acto que no sigue buenas prácticas.

Ejemplos de fraude y abuso de participantes son:

- Permitir que otra persona utilice su tarjeta de seguro médico de Medicaid, PeachCare for Kids® o CMO.
- Obtener recetas con la intención de abusar de o vender drogas
- Usar documentos falsificados para obtener servicios
- Usar indebidamente o abusar del equipo provisto por Medicaid o PeachCare for Kids®
- Proporcionar información incorrecta o permitir a otros que lo hagan para obtener elegibilidad para Medicaid o PeachCare for Kids®
- Evitar informar cambios que ocurren en ingresos, acuerdos de vida o recursos.

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 dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

Página de Firma

He recibido una copia del Formulario 297A, Derechos y responsabilidades para los beneficios.

Certifico, bajo pena de perjurio, que toda la información proporcionada y todo lo que he dicho es la completa verdad, a mi saber y entender.

Firma Fecha

Representante autorizado / Testigo / Persona responsable Fecha

Departamento de Servicios Humanos de Georgia División de Servicios para Familias y Niños Aviso de requisito de cooperación y derecho a reclamar una causa justificada para negarse a cooperar en los servicios de manutención infantil y requisitos de responsabilidad de terceros

Beneficios de los servicios de manutención infantil

Su ayuda en el proceso de los servicios de manutención infantil puede ser valiosa para usted y su hijo porque puede resultar en lo siguiente:

- Encontrar al padre ausente.
- Establecer legalmente la paternidad de su hijo.
- Recibir pagos de manutención infantil que pueden darle más dinero que si recibe la Asistencia Temporal para Familias Necesitadas (TANF)

- Adquirir un seguro médico privado a través del padre ausente.
- Adquirir derechos a futuros beneficios del Seguro Social, veteranos u otros beneficios gubernamentales.

Cooperación con la DFCS y la DCSS

La ley requiere que ayude a la División de Servicios para Familias y Niños (DFCS) y la División de Servicios de Manutención Infantil (DCSS) a obtener cualquier manutención que se le deba a usted y a los niños para quienes se solicita TANF, a menos que tenga una causa justificada para no ayudar.

Para ayudar a la DFCS o a la DCSS, debe hacer una o más de las siguientes acciones:

- Nombrar los padres ausentes de cualquier niño para el que solicita TANF o Medicaid.
- Proporcionar información para ayudar a encontrar a los padres ausentes.
- Ayudar a determinar quién es el padre legal si su hijo nació fuera del matrimonio.
- Aceptar hacerse un análisis de sangre si la persona que nombra como padre niega la paternidad.
- Ayudar al estado a obtener el dinero que se le debe a usted o al niño que recibe TANF.
- Proporcionar información sobre el seguro médico que el padre ausente tiene con su hijo.

Debe acudir a la oficina de la DFCS, la DCSS o al tribunal para firmar documentos o proporcionar la información necesaria.

Causa justificada

Es posible que tenga una causa justificada para no querer ayudar a la DCSS a cobrar la manutención infantil o la cobertura médica para su hijo. Es posible que no tenga que ayudar si cree que ayudar no es lo mejor para su hijo y si puede probarlo. Si desea reclamar una causa justificada, debe informar al administrador de su caso. Puede hacer esto en cualquier momento.

Si no ayuda y no tiene una causa justificada

- No será elegible para recibir TANF para usted y su hijo.
- Es posible que su hijo aún sea elegible para recibir Medicaid.

Razones de causa justificada

Puede reclamar una causa justificada por cualquiera de las siguientes razones:

- Su ayuda puede causarle graves daños físicos o emocionales a su hijo o a usted.
- El niño nació como resultado de una violación o incesto.
- Se están llevando a cabo procedimientos judiciales para la adopción del niño.
- Una agencia lo está ayudando a decidir si coloca al niño en adopción.

Para probar una causa justificada, debe

- Brindar a la DFCS la información que necesita para decidir si tiene una causa justificada para

no ayudar. Si teme sufrir daños físicos y no puede obtener pruebas, es posible que la DFCS aún pueda hacer una determinación de causa justificada.

- Entregar prueba a la DFCS dentro de los 20 días de haber reclamado una causa justificada. La DFCS le dará más tiempo solo si tiene problemas para obtener pruebas.

La DFCS puede excusarlo de ayudar en función de la información que proporcione. O la DFCS puede pedirle que proporcione más información. La DFCS no se comunicará con el padre ausente sin avisarle.

AVISO: Si está solicitando TANF, no será aprobado hasta que le dé a la DFCS prueba de su reclamo de causa justificada o la información que la DFCS necesita para investigar su reclamo.

EJEMPLOS DE PRUEBA DE CAUSA JUSTIFICADA

- certificado de nacimiento, registros médicos o policiales que demuestren que el niño nació como resultado de una violación o incesto
- documentos judiciales u otros documentos legales que demuestren que se han iniciado los procedimientos de adopción
- registros judiciales, médicos, penales, de protección infantil, servicios sociales, psicológicos o policiales que demuestren que el padre ausente puede lastimarlo a usted o al niño
- registros médicos o declaraciones escritas de un profesional de la salud mental que muestren el historial y el estado actual de su salud emocional o la del niño
- una declaración escrita de una agencia pública o privada que demuestre que se le está ayudando a decidir si entrega a su hijo en adopción
- declaraciones juradas de amigos, vecinos, clérigos, trabajadores sociales o profesionales médicos que saben por qué tiene una causa justificada.

Si necesita ayuda para obtener alguno de los documentos, consulte con el administrador de su caso.

Normas de la manutención infantil

Si recibe TANF, le otorga al estado de Georgia, por ley, cualquier derecho que tenga para recibir manutención infantil. Una vez que se establece la orden judicial, el padre ausente deberá pagar la manutención de los hijos a través de la DCSS. Después de que se establezca la orden judicial, se le pedirá que informe cualquier dinero que reciba directamente del padre ausente. También debe ayudar a establecer la paternidad de su hijo y cooperar con la DCSS para establecer una orden de manutención infantil. Si no coopera y no tiene una causa justificada, es posible que no sea elegible para recibir TANF.

Si recibe TANF y el padre ausente paga la manutención de los hijos a través de la División de Servicios de Manutención Infantil (DCSS), probablemente NO recibirá el monto total del pago de la manutención infantil. En su lugar, puede recibir un pago de "brecha". La DCSS retiene toda la manutención infantil pagada por un padre ausente, que excede el monto de la "brecha", y se utiliza para devolver los fondos de TANF que ha recibido. ***El administrador de su caso de TANF puede explicarle el presupuesto de brecha y los procedimientos de pago.***

Si se cierra su caso de TANF, se le enviarán pagos de manutención infantil hasta el monto de la

obligación mensual actual del padre ausente. El estado retendrá cualquier monto de manutención infantil que se pague sobre la obligación actual para reembolsar las subvenciones anteriores de TANF que haya recibido. Una vez que se paguen las subvenciones anteriores de TANF, se le enviará toda la manutención infantil pagada por el padre ausente.

Si su caso de TANF se cierra y *luego se vuelve a abrir, cualquier pago atrasado de manutención infantil adeudado será asignado al estado hasta* la cantidad de todo el dinero de TANF que haya recibido. Cuando se reembolse la Asistencia Pública No Reembolsada (UPA, en inglés), comenzará a recibir los pagos atrasados que se le adeuden.

Si recibe pagos de manutención de menores a los que no tiene derecho, es posible que deba reembolsar al estado. El estado le notificará el monto del sobrepago y el plazo para el reembolso.
La DCSS puede revisar la decisión de causa justificada de la DFCS en su caso. Si solicita una audiencia sobre la decisión, la DCSS puede participar en la audiencia.

Si tiene una causa justificada para no ayudar, la DCSS no intentará establecer la paternidad ni cobrar la manutención infantil.

He leído este aviso sobre mis derechos para reclamar una causa justificada y no ayudar a establecer la paternidad o cobrar la manutención de los hijos del padre ausente.

La violencia doméstica le puede pasar a CUALQUIERA.

- La violencia doméstica se da en todos los niveles socioeconómicos, sin importar el empleo o la educación, la raza o el origen étnico, la religión, el estado civil, la capacidad física, la edad o la orientación sexual.
- Cada año se informan a las agencias de aplicación de la ley de Georgia más de 50,000 incidentes de violencia doméstica.
- Más del 50 por ciento de todas las mujeres son maltratadas por parejas íntimas en algún momento de sus vidas.
- Una mujer es abusada físicamente cada 9 segundos en este país, se estima que entre 2 y 4 millones de mujeres al año.
- El maltrato es la principal causa de lesiones a las mujeres en los Estados Unidos, más que la violación, el atraco o los accidentes automovilísticos combinados.
- A nivel nacional, el 50 por ciento de todas las mujeres y niños sin hogar están en las calles debido a la violencia en el hogar.
- Entre el 15 y el 25 por ciento de las mujeres embarazadas son maltratadas.
- La Oficina Federal de Investigaciones (FBI, en inglés) estima que solo se informa de 1 de cada 10 incidentes de violencia doméstica.
- Cada día, 4 mujeres en Estados Unidos son asesinadas por su pareja.

PARA OBTENER MÁS INFORMACIÓN

Hay servicios gratuitos y confidenciales disponibles en los refugios para víctimas de violencia doméstica y los programas apoyados por el Departamento de Servicios Humanos.

PARA OBTENER AYUDA LAS 24 HORAS DEL DÍA, LLAME AL (800) 334-2836

Llame a este número de teléfono gratuito para hablar con alguien del centro de acogida para víctimas de violencia doméstica local. Puede llamar desde cualquier lugar del estado para encontrar un lugar seguro para usted y sus hijos y obtener otros recursos de ayuda.

¿Qué es la violencia doméstica, el acoso sexual, la agresión sexual o el acoso?

- La **violencia doméstica** puede incluir ser golpeado, pateado, agredido, violado, estrangulado, amenazado, controlado o impedido de obtener lo que necesita para vivir (como comida, medicina o una casa) por parte de un cónyuge, novio, pareja o "ex".
- El **acoso sexual** es un comportamiento hostil, intimidatorio u opresivo basado en el sexo que crea un ambiente de trabajo abusivo.
- La **agresión sexual** es un acto sexual no consentido proscrito por la legislación federal, tribal o estatal, incluso cuando la víctima carece de capacidad de consentimiento.
- El **acoso** es el acto o delito de seguir o hostigar de manera intencionada y repetida a otra persona en circunstancias que harían temer a una persona razonable que se produjeran lesiones o la muerte, en especial debido a amenazas expresas o implícitas.

El Departamento de Servicios para Familias y Niños de su localidad desea ayudarlo a usted y a sus hijos a mantenerse seguros.

Si le ocurre alguna de estas cosas, hable con su administrador del caso

- ¿Alguna vez su cónyuge, pareja, novio o "ex" le ha golpeado o abofeteado?
- ¿Alguna vez esta persona ha amenazado con hacerle daño?
- ¿Esta persona ha amenazado con llevarse a sus hijos?
- ¿La persona le insulta o actúa celosa?
- ¿Alguna vez ha sentido que esta persona está controlando su vida o lo mantiene alejado de su familia y amigos, o le impide ir al trabajo o la escuela?
- ¿La persona realiza un seguimiento de lo que hace, a dónde va o con quién habla por teléfono?
- ¿La persona destruye cosas que le pertenecen o que le importan?
- ¿Le tiene miedo a esta persona?
- ¿Es peligroso para usted regresar a su hogar?

Si respondió SÍ a cualquiera de las preguntas, puede ser el momento de pensar en la seguridad para usted y sus hijos.

Violencia doméstica y TANF

- Es posible que algunos de los requisitos de la Asistencia Temporal para Familias Necesitadas (TANF) no correspondan a usted.
- Puede informar a un administrador de casos de la DFCS **en cualquier momento** que su pareja está siendo violenta.
- La DFCS lo derivará a alguien con quien pueda hablar sobre su situación.
- La DFCS le ayudará con asistencia, un lugar seguro donde alojarse para usted y sus hijos, aten-

ción médica y de salud mental, tratamiento para adicciones y ayuda especial para víctimas de delitos y violencia doméstica.

- La DFCS no compartirá la información con nadie fuera de la agencia sin su conocimiento.
- Informe a la DFCS cuando ya no se encuentre en una situación peligrosa.

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 lengua 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 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 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 lengua 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, (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.

También puede presentar un reclamo por discriminación ante la agencia federal correspondiente. La información de contacto del Departamento de Agricultura de EE. UU. (USDA, en inglés) y del Departamento de Salud y Servicios Humanos (HHS, en inglés) de
EE. UU. se encuentra dentro de la "Declaración conjunta de no discriminación USDA-HHS" incluida en este documento.

** 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 ala política del **Departamento de Salud Comunitaria (DCH, en inglés)**, los programas de Asistencia Médica no pueden negarle la elegibilidad o los beneficios en función de su raza, edad, sexo, discapacidad, origen nacional o creencias políticas o religiosas.

No envíe solicitudes al USDA o al HHS **Declaración de no discriminación** De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de EE.UU. (USDA, en inglés), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo (lo que incluye la identidad de género y la orientación sexual), credo religioso, discapacidad, edad, creencias políticas, o en represalia o venganza por actividades previas de derechos civiles en algún programa o actividad realizados o financiados por el USDA. Los programas que reciben asistencia financiera federal por parte del Departamento de Salud y Servicios Humanos (HHS, en inglés) de EE.UU., como la Asistencia Temporal para Familias Necesitadas (TANF), y los programas que el HHS opera directamente, también tienen prohibido discriminar según las leyes federales de derechos civiles y los reglamentos del HHS.

Las personas con discapacidades que requieren medios alternativos de comunicación para obtener información acerca del programa (por ejemplo, braille, letra grande, cinta de audio, lengua de señas estadounidense) deben contactar a la agencia (estatal o local) donde solicitaron los beneficios. Las personas sordas, con problemas de audición o con discapacidades del habla pueden comunicarse con el USDA a través del servicio de retransmisión federal al (800) 877-8339. Además, es posible que la información acerca del programa se encuentre disponible en otro idioma que no sea el inglés.

RECLAMOS DE DERECHOS CIVILES QUE INVOLUCRAN A LOS PROGRAMAS DEL USDA
El USDA brinda asistencia financiera federal para muchos programas de seguridad alimentaria y DE reducción del hambre, como el Programa de Asistencia Nutricional Suplementaria (SNAP), el Programa de Distribución de Alimentos en Reservas Indígenas (FDPIR) y otros. Para presentar un reclamo de discriminación del programa, complete el formulario de reclamo por discriminación del programa (AD- 3027) que se encuentra en línea en

https://www.usda.gov/sites/default/files/documents/USDA-OASCR P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, y en cualquier oficina del USDA, o escriba una carta dirigida al USDA y proporcione en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de reclamo, llame al (866) 632-9992. Envíe su formulario completo o carta al USDA por:

1. **correo:** Food and Nutrition Service, USDA

1320 Braddock Place, Room 334, Alexandria, VA 22314; o

2. **fax:** (833) 256-1665 o (202) 690-7442; o
3. **teléfono**: (833) 620-1071; o
4. **correo electrónico:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

Para obtener cualquier otra información relacionada con los asuntos de SNAP, las personas deben comunicarse con la línea directa de SNAP del USDA al (800) 221-5689, que también está en español, o llamar a los números de información/línea directa del estado (haga clic en el enlace para obtener una lista de los números de línea directa por estado); que se encuentran en línea en: línea directa de SNAP .

RECLAMOS DE DERECHOS CIVILES QUE INVOLUCRAN A LOS PROGRAMAS DEL HHS
El HHS brinda asistencia financiera federal para muchos programas para mejorar la salud y el bienestar, lo que incluye los programas TANF, Head Start, el programa de asistencia de energía para hogares de bajos ingresos (LIHEAP) y otros. Si cree que ha sido discriminado por su raza, color, nacionalidad, discapacidad, edad, sexo (lo que incluye el embarazo, la orientación sexual y la identidad de género) o religión en programas o actividades que el HHS opera directamente o a las que el HHS proporciona asistencia financiera federal, puede presentar un reclamo ante la Oficina de Derechos Civiles (OCR) en su nombre o por otra persona.

Para presentar un reclamo de discriminación en su nombre o para otra persona con respecto a un programa que recibe asistencia financiera federal a través del HHS, complete el formulario en línea a través del portal de reclamos de la OCR en https://ocrportal.hhs.gov/ocr/. También puede comunicarse con la OCR por correo a: Operaciones Centralizadas de Gestión de Casos, Departamento de Salud y Servicios Humanos, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; fax: (202) 619-3818; o por correo electrónico a: OCRmail@hhs.gov. Para un procesamiento más rápido, lo alentamos a que use el portal en línea de la OCR para presentar reclamos en lugar de enviarlos por correo. Las personas que necesiten ayuda para presentar un reclamo de derechos civiles pueden enviar un correo electrónico a la OCR a OCRMail@hhs.gov o llamar sin cargo a la OCR al 1-800-368-1019, TDD 1-800-537-7697. Para las personas sordas, con dificultades auditivas o del habla, marque el 7-1-1 para acceder a los servicios de retransmisión de telecomunicaciones. También proporcionamos formatos alternativos (como Braille y letra grande), ayudas auxiliares y servicios de asistencia con el idioma sin cargo para presentar un reclamo.

Esta institución es un proveedor que ofrece igualdad de oportunidades.

Conforme al Departamento de Servicios Humanos (DHS), también puede presentar otros reclamos de discriminación al comunicarse con la oficina del DFCS de su localidad, o con el Coordinador de Derechos Civiles del DFCS, ADA/Sección 504 en 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (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, (877) 423-4746.

No envíe solicitudes al USDA o al HHS

Form 297A SP LP Rights & Responsibilities (Spanish) (Large Print)

Form 298Q Q Track Addendum Renewal

Form 315 Official Notice of Georgia Medicaid Estate Recovery Program

Form 315 LP Official Notice of Georgia Medicaid Estate Recovery Program (Large Print)

Form 315 SP Official Notice of Georgia Medicaid Estate Recovery Program (Spanish)

Form 315 SP LP Official Notice of Georgia Medicaid Estate Recovery Program (Spanish) (Large Print)

Form 327 Estate Recovery Notification

Form 328 Quarterly Report Form (QRF)

Form 403 Adoption Assistance Benefits Memorandum

Form 411 Undue Hardship Application

Form 508 Food Stamp, TANF, Medicaid Renewal

Form 508 LP Food Stamp, TANF, Medicaid Renewal Form (Large Print)

Form 508 SP Food Stamp, TANF, Medicaid Renewal Form (Spanish)

Form 508 SP LP Food Stamp, TANF, Medicaid Renewal Form (Spanish) (Large Print)

Form 512 Notification of Eligibility - EMA

Form 512 SP Notification of Eligibility - EMA (Spanish)

Si Ud reúne los requisitos para recibir Asistencia del programa de Medicaid De Emergencia (EMA en Ingles), Ud recibirá una carta que certifica las fechas en las cuales Medicaid aseguró el pago del (los) servicio(s). El Médico o proveedor de salud que lo atiende proveyó la información que usamos para determinar las fechas de la certificación durante el proceso donde se verifica si Ud. es elegible para este programa. Alliant Health Soultions (AHS) es la que hace la decisión final acerca de si un servicio médico se define como una emergencia.

“Servicios de Emergencia” son aquellos que son:

- Médicamente necesarios y
- Es el resultado de alguna condición que comienza repentinamente (súbitamente) en algún área de la salud con síntomas agudos (muy recientes) (incluye el trabajo de parto y el parto mismo) y
- Los cuales en ausencia de atención medica inmediata, es razonablemente probable que resulte en una de las siguientes situaciones:
    - Poniendo la salud de los individuos en serio peligro
    - Daño serio de las funciones del organismo (cuerpo) o
    - Alteración seria de la función de cualquier órgano o parte de él

Solo los servicios que están totalmente descritos en la definición federal como una condición **médica de emergencia** serán cubiertos (pagados) comenzando el 1 de Enero del 2006. No todos los servicios que son médicamente necesarios están descritos en esta definición. Ciertos tipos de cuidados suministrados a personas con enfermedades crónicas están más alla de las decisiones de la ley federal y no son considerados como servicios de emergencia. Tales cuidados incluyen diferentes niveles de servicios alternativos en un hospital, servicios de enfermería, cuidados en casa o personales.

Solo determinados servicios descritos en la definición federal como “emergencia” y determinado por Alliant Health Solutions (AHS) serán cubiertos (pagados). Su medico o proveedor de salud le puede cobrar directamente a Ud. por todos los servicios que no estén contemplados en la definición de emergencia. **Esta establecido que cualquier servicio prestado después de la condición de emergencia no sera pagado.**

Toda la información que he dado es verdadera y completa hasta donde yo se.

Firmando al final de esta forma, dejo constancia que conozco y entiendo que solo esos reclamos o condiciones contemplados en la definición federal como una emergencia y determinado por Alliant Health Solutions pueden ser pagados por el programa de Medicaid.

Firma Fecha

Form 526 Physician’s Statement for EMA

Form 700 Application for Medicaid Medicare Savings for Qualified Beneficiaries

Form 700 SP Application for Medicaid Medicare Savings for Qualified Beneficiaries (Spanish)

Form 701 Q-Track Brochure

Form 703 Medicare Buy-In Problem Template

Form 704 TEFRA/Katie Beckett Cost Effectiveness

Form 705 TEFRA/Katie Beckett LOC Determination Routing

Form 706 TEFRA/Katie Beckett Medical Necessity LOC Statement

Form 713 Interagency Interoffice referral/ Follow Up

Form 809 Verification of Earned Income

Form 809 SP Verification of Earned Income (Spanish)

Form 936 QIT Certification

Form 937 QIT Review Letter

Form 942 IME Verification

942i Instructions for IME Verification Form

The following are requirements for Form 942:

- “Name of Medicaid Member” (Must be A/R) and “Medicaid ID# (either SUCCESS or MHN ID #)
- “Name of Customer” (must be A/R), “Date of Service”, “Cost of service” (cost of Rx , procedure, orthodic, etc.)
- “Description of Services Give NDC# for Drugs” (describe what was provided, if RX provide NDC #)
- For “Drugs” provide the # of tablets or capsules and the # of grams or milliliters.
- The question, "Was this service ordered in writing by a doctor?" must be answered YES. If NO, it can’t be considered as an IME.
- “Is the customer financially obligated to pay for the Above Services?” In order to be considered as an IME, the answer must be YES.
- “Are you a Medicaid–participating provider? Must be answered Yes or No.
- The pharmacist must answer questions 1 – 4 if the service was for a drug.
- “Name of Medical Care Provider” must be typed or printed.
- The provider must include his/her Provider Number in the space “Medicaid Provider Number”.
- “Signature of Provider” - The signature of the provider must be an original signature; photo-copied or stamped signatures are unacceptable.
- The “Date” should be the date signed by the provider.

Financially obligated means the item or service is not covered by Medicare or other health insurance and liability for the item or service has not been written off or forgiven by the provider.

Revision Date: 10/06

Form 943 Notification of Deduction of Medical Expense

Form 944 IME Query Form

Form 945 QIT Trustees Guide

Form 946 FAQ and Worksheet

Form 950 Facility Action Request

Form 954 Optum Rx Prescription Update Template

Form 955 Notice of Review of Promissory Note, Loan, or Property Agreement

Form 957 Resource Clearance

Form 958 Nursing Facility Information Request

962i Instructions for Form DMA 962: Action Request / Certification Form

Purpose

The form DMA 962, Action Request/Certification Form, should be used by the Authorized worker to have Gainwell Technologies update GAMMIS by adding and/or correcting eligibility information. Gainwell Technologies will update GAMMIS within three (3) business days after receipt of the Form DMA 962.

Instructions

FAX To: Gainwell Technologies, Fax 1-866-483-1045

County DFCS Office:

- Enter the county DFCS name and mailing address

Member's Mailing Address:

- Enter the member's mailing address

Add/Correction Box:

- Select the "Add" box if the person is not known to Gateway or for newly approved SSI members
- Check the "Correction" box if the person is known to GA Gateway.

Member Name and Case Number:

- Enter the GA Gateway head of the household member's name or the SSI member's name.
- Enter the GA Gateway Case Number or the SSI Medicaid number.

Eligibility Status: (Check only one box)

- Approved Ongoing
- Denied Ongoing

Please Check All that Apply:

- **Add Eligibility and/or Aid Category** – For one member or the entire case. If eligibility cannot be added in IES due to technical issues, an IES Help desk ticket number **must** be added in the case notes section. (Refer to Appendix C for the emergency update procedure).
- **Add/Correct Long Term Care Provider** - For member showing incorrect or missing Long Term Care Provider.
- **Add SSI Certification** – For members who are not updated on GAMMIS and are receiving SSI. A SSI Certification letter is needed. Fax to Gainwell Technologies with the Form DMA 962.
- **Add/Correct Patient Liability** – For Members showing incorrect or missing patient liability.

- **Correct/Merge/Link Duplicate Member ID Numbers** – The original Medicaid ID number is to be kept, and will be noted here. In the comment section note the incorrect duplicate Medicaid ID number(s) that should be merged/link. To update member information GA Gateway must show the correct information.
- **Add Historical Months** – Any COA updates needed prior to 13 months must be manually updated on GAMMIS and must be documented in the case notes section in Gateway. The case notes should include information regarding how the eligibility was determined for the member including but not limited to income, resources, disability, EMA 526 dates, etc.
- **Add/Correct Medically Needy BAD/FDL** - For any historical Spend Down cases (F99, S99, and P99). When a correction is needed on a previously approved Spend Down case either due to worker error or the member returned additional bills within the last 3 months of the Spend Down completion.
- **Remove Transfer of Resource Penalty-** If the member has a transfer penalty that should be removed or adjusted in GAMMIS. TOR's must be manually removed from GAMMIS.
- **Documentation in the case notes section in GA Gateway is required for all actions listed above.**

Identifying Information:

- Enter the **Member's name** and the **GAMMIS Member ID number** (If a GAMMIS Member ID has not yet been assigned HP can screen on the name, SSN, DOB and GA Gateway client ID number. However, if the GAMMIS Member ID number is available it must be on the form). This form may be used to update one or more case members. If the head of household is to be updated the head of household is always entered on the first line.
- Enter the **client ID number** found in GA Gateway. No ID number will be entered here for SSI members who only receive SSI Medicaid.
- Enter the member's **race** (see list of codes following these instructions)
- Enter the member's **gender** (Male or Female)
- Enter **date of birth** (DOB) in the following format XX/XX/XXXX
- Enter the member's **social security number** (SSN)
- Enter the GAMMIS 3 digit **aid category code** (see list of codes following these instructions)
- Enter the eligibility **Start date** and **End date** in the month and year format for all Classes of Assistance (COA). If the individual is approved for EMA, enter Start date **and** End date in the month, day and year format and enter EMA in the comment section Consecutive prior months may be grouped together, when entered but the end date will be no later than the last day of the current month. No ongoing date will be entered in the End date field.

Medically Needy (S99, F99, and P99) Information:

- Enter the first day liability (FDL) amount
- Check "Y" when form DMA 400 is required and "N" if no form DMA 400 is required
- If the spend down is met by a pharmacy bill, check "Y", otherwise check "N"

Comments:

- Please include comments to explain your desired action if it is not captured on the 962.

  Example:

  - ☑ Incorrect Duplicate ID(s) are 222XXXXXXXX and 11XXXXXXXX.
  - ☑ Correct name is linked to number 22222XXXXXXXXX
  - ☑ Please remove TOR (Transfer of Resource) effective 06/2018.

DFCS Authorized Worker Information:

- Type or print the Authorized worker's name in the first blank field. The Authorized worker is the individual responsible for this action request.
- Sign the form in the second blank field and enter the official DFCS title underneath the signature.
- Enter the direct phone number of the Authorized worker.
- Form DMA 962 should NEVER be given to a provider such as a NH, Hospice Provider, or cost recovery agency.

GAMMIS Aid Codes

104	Parent Caretaker With Children -Adult
105	Parent Caretaker With Children -CHILD
118	TRANS MED ASSIST - ADULT
119	TRANS MED ASSIST - CHILD
122	4 MEX – ADULT
123	4 MEX – CHILD
131	FOSTER CARE
132	STATE FUNDED ADOPTION ASSIST
133	IV-E FOSTER CARE
134	IV-E ADOPTION ASSISTANCE
135	NEWBORN CHILD
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
177	FAMILY PLANNING WAIVER
194	RSM EXPANSION PREGNANT WOMAN
197	RSM PREG WOMAN, INCOME > 185 FPL

WAIVERS

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

ABD Medicaid

210	NURSING HOME – AGED
211	NURSING HOME – BLIND
212	NURSING HOME – DISABLED
215	30 DAY HOSPITAL - AGED
216	30 DAY HOSPITAL – BLIND
217	30 DAY HOSPITAL - DISABLED
218	PROTECTED MED /1972 COLA - AGED
219	PROTECTED MED/1972 COLA - BLIND
220	PROTECTED MED/1972 COLA - DISABLED
221	DISABLED WIDOWER 1984 COLA - AGED
222	DISABLED WIDOWER 1984 COLA - BLIND
223	DISABLED WIDOWER 1984 COLA - DISABLED
224	PICKLE – AGED
225	PICKLE – BLIND
226	PICKLE - DISABLED
227	DISABLED ADULT CHILD – AGED
228	DISABLED ADULT CHILD – BLIND
229	DISABLED ADULT CHILD – DISABLED
230	DISABLED WIDOWER AGE 50-59, AGED
231	DISABLED WIDOWER AGE 50-59, BLIND
232	DISABLED WIDOWER AGE 50-59, DISABLED
233	WIDOWER AGED 60-64 – AGED
234	WIDOWER AGED 60-64 – BLIND
235	WIDOWER AGED 60-64 - DISABLED
236	3 MO. PRIOR MEDICAID - AGED
237	3 MO PRIOR MEDICAID – BLIND
238	3 MO PRIOR MEDICAID - DISABLED
239	ABD MED. NEEDY DEFACTO - AGED

240	ABD MED. NEEDY DEFACTO - BLIND
241	ABD MED. NEEDY DEFACTO - DISABLED
242	ABD MED. NEEDY SPENDDOWN - AGED
243	ABD MED. NEEDY SPENDDOWN - BLIND
244	ABD MED. NEEDY SPENDDOWN - DISABLED
245	WOMEN'S HEALTH MEDICAID
246	GEORGIA MEDICAID WORKING DISABLED
250	DEEMING WAIVER
280	HOSPICE - AGED
281	HOSPICE - BLIND
282	HOSPICE - DISABLED
289	INSTITUTIONAL HOSPICE - AGED
290	INSTITUTIONAL HOSPICE - BLIND
291	INSTITUTIONAL HOSPICE - DISABLED

SSI MEDICAID

301	SSI – AGED
302	SSI – BLIND
303	SSI – DISABLED
304	SSI APPEAL – AGED
305	SSI APPEAL – BLIND
306	SSI APPEAL – DISABLED
307	SSI WORK CONTINUANCE - AGED
308	SSI WORK CONTINUANCE – BLIND
309	SSI WORK CONTINUANCE - DISABLED
315	SSI ZEBLEY CHILD
321	SSI E02 MONTH– AGED
322	SSI E02 MONTH - BLIND
323	SSI E02 MONTH - DISABLED
387	SSI TRANS. MEDICAID - AGED
388	SSI TRANS. MEDICAID – BLIND
389	SSI TRANS. MEDICAID - DISABLED

SSI EX-PARTE DETERMINATION MEDICAID

410	NURSING HOME - AGED
411	NURSING HOME – BLIND
412	NURSING HOME – DISABLED
424	PICKLE – AGED
425	PICKLE – BLIND
426	PICKLE - DISABLED
427	DISABLED ADULT CHILD – AGED

428	DISABLED ADULT CHILD – BLIND
429	DISABLED ADULT CHILD – DISABLED
445	N07 CHILD
446	WIDOWER - AGED
447	WIDOWER - BLIND
448	WIDOWER - DISABLED
471	RSM CHILD
460	QUALIFIED MEDICARE BENEFICIARY
466	SPECIFIED LOW INCOME MEDICARE BENEFICIARY

REFUGEE MEDICAID

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

Q TRACK MEDICAID

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

PEACHCARE

790	PEACHCARE 101 – 150 % FPL
791	PEACHCARE 151 – 200% FPL
792	PEACHCARE 201 – 247% FPL
793	PEACHCARE > 247% FPL
794	360 FC PEACH 101 – 150% FPL
795	360 FC PEACH 151 - 200% FPL
796	360 FC PEACH 201 - 247% FPL
797	360 FC PEACH > 247% FPL

P4HB

180	P4HB INTER PREGNANCY CARE
181	P4HB FAMILY PLANNING ONLY
182	P4HB RESOURCE MOTHER – PARENT/CARETAKER WITH CHILDRN
183	P4HB RESOURCE MOTHER - ABD/SSI

HOSPITAL PRESUMPTIVE

801	PE ADULT PARENT/CARETAKER WITH CHILD(REN)

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

PRESUMPTIVE / OTHER MEDICAID

800	WOMEN HEALTH MEDICAID (WHM)
835	NEWBORN
864	PE PREGNANT WOMAN

HIPPA RACE CODES

NOT PROVIDED	7
NOT APPLICABLE	8
ASIAN	A
BLACK	B
CAUCASIAN	C
SUBCONTINENT ASIAN AMERICAN	D
OTHER	E
ASIAN PACIFIC AMERICAN	F
NATIVE AMERICAN	G
HISPANIC	H
AMERICAN INDIAN OR ALASKAN	I
NATIVE HAWAIIAN	J
BLACK (NON-HISPANIC)	N
WHITE (NON-HISPANIC)	O
PACIFIC ISLANDER	P
MUTUALLY DEFINED	Z

Revision Date: 12/2020

Form 968 MN PL Budget Sheet

Form 969 Living Arrangement Determination - LA/ISM Guide

Form 970 VA Communication Form

Form 981 Contact Letter and Information/Verification Checklist for Aged, Blind and Disabled Medicaid

Form 981 SP Contact Letter and Information/Verification Checklist for Aged, Blind and Disabled Medicaid (Spanish)

Form 985 Burial Exclusion and Designation

Form 986 MAO Cemetery Lot Verification

Form 987 Designation of Cemetery Lot

Form 988 Notice of Review of Annuity

Form 991 MAO Property Search Record

Form 992 MAO Control Sheet

Form 995 Pathways Qualifying Activities Report Form

Form 996 Pathways Good Cause, RM and RA

Form 3327 Health Check Brochure - English

Form 5459 Authorization for Release of Information

Form 5459 SP Authorization for Release of Information (Spanish)

5460 Notice of Privacy Practices (English)

Notice of Privacy Practices Georgia Department of Human Services

Date: August 01, 2022

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this notice.

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

Obligations of The Department of Human Services:

DHS is required by law to:

- Maintain the privacy of your personal information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

Information we Collect:

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

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

How DHS May Use and Disclose Personally Identifiable Information:

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

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

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

How DHS May Use and Disclose Health Information:

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

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

For Treatment. DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, DHS may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform information technology services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the correctional insti-

tution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require DHS to Provide You an Opportunity to Object and Opt Out:

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

Your Written Authorization is Required for Other Uses and Disclosures:

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures of Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Health Information.

Your written permission is necessary before your health records are shared for any other reason not authorized by law. If you do provide DHS with a written authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer at the contact information below. Upon receipt, DHS will no longer disclose Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

Your Rights:

You have the following rights regarding information DHS has about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the below referenced Privacy Officer. DHS has up to 30 days to make your Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Health Information in the form or format you request if it is readily producible in such form or format. If the Health Information is not readily producible in the form or format you request, your

record will be provided in either our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that DHS has is incorrect or incomplete information about you, you may request DHS to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To make changes, you can go through your user portal, contact customer service for the program to which you are applying, contact your case manager, or make your request, in writing, to the below referenced Privacy Officer. We encourage you to review your information on a regular basis to make sure it is correct.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures DHS made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid “out-of-pocket” in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the Privacy Officer. You may also obtain a copy from the DHS website, on the Office of General Counsel homepage: 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 dhs.georgia.gov/organization/about/division-offices/office-general-counsel. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints:

If you have any questions about this notice, please contact:

Georgia Department of Human Services
Privacy Officer
2 Peachtree Street NW, 29th Floor
Atlanta, GA 30303-3142
HIPAADHS@dhs.ga.gov

If you believe your privacy rights have been violated, you may file a complaint in writing by contacting the above-referenced Privacy Officer. Please include your name, phone number, case number and a description of the complaint.

You will not be penalized for filing a complaint.

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

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

CONSENT:

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

[SIGNATURE PAGE TO FOLLOW]

Signature Page

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

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

Signature Date

Print Name

Return Address:

[Insert Local Address here]

5460 SP Notice of Privacy Practices (Spanish)

Aviso de prácticas de privacidad Departamento de Servicios Humanos de Georgia

Fecha: 01 de agosto de 2022

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

LEA CON ATENCIÓN ESTE AVISO.

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

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

OBLIGACIONES DEL DEPARTAMENTO DE SERVICIOS HUMANOS:

El DHS está obligado por ley a:

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

INFORMACIÓN QUE RECOPILAMOS:

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

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

CÓMO PUEDE EL DHS UTILIZAR Y DIVULGAR LA INFORMACIÓN PERSONAL:

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

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

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

CÓMO PUEDE UTILIZAR Y DIVULGAR DHS INFORMACIÓN MÉDICA:

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

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

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

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

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

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

Información Médica.

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

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

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

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

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

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

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

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

SUS DERECHOS:

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

Derecho a inspeccionar y hacer copias. Tiene derecho a inspeccionar y hacer copias de la Información Médica que pueda utilizarse para tomar decisiones sobre su cuidado o el pago de su cuidado. Esto incluye los registros médicos y de facturación, que no sean notas de psicoterapia. Para inspeccionar y obtener una copia de esta Información Médica, debe presentar su solicitud, por escrito, al Oficial de Privacidad mencionado más abajo. El DHS tiene hasta 30 días para poner a su disposición su Información Médica y el DHS puede cobrarle una tarifa razonable por los costos de

las copias, el envío por correo u otros suministros relacionados con su solicitud. El DHS no puede cobrarle una tasa si necesita la información para una solicitud de prestaciones en virtud de la Ley de la Seguridad Social o de cualquier otro programa estatal o federal de prestaciones basadas en las necesidades. El DHS puede denegar su solicitud en determinadas circunstancias limitadas. Si el DHS deniega su solicitud, usted tiene derecho a que la denegación sea revisada por un profesional de la salud autorizado que no haya participado de forma directa en la denegación de su solicitud, y el DHS cumplirá con el resultado de la revisión.

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

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

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

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

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

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

Derecho a una copia en papel de este aviso. Tiene derecho a recibir una copia en papel de este aviso. Puede solicitar una copia de este aviso en cualquier momento. Aunque haya aceptado recibir este aviso por vía electrónica, tiene derecho a recibir una copia en papel de este aviso. Para obtener una copia en papel de este aviso, póngase en contacto con el Oficial de Privacidad. También puede obtener una copia en el sitio web del DHS, en la página de inicio de la Oficina del Asesor General: dhs.georgia.gov/organization/about/division-offices/office-general-counsel

PROTECCIONES:

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

CAMBIOS EN ESTE AVISO:

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

RECLAMOS:

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

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

Si cree que se han violado sus derechos de privacidad, puede presentar un reclamo por escrito si se pone en contacto con el Oficial de Privacidad mencionado anteriormente. Incluya su nombre, número de teléfono, número de caso y una descripción del reclamo. **No se le sancionará por presentar un reclamo.** También puede presentar su reclamo ante la Oficina de Derechos Civiles (OCR, en inglés) del Departamento de Salud y Servicios Humanos de los Estados Unidos. Para obtener más información sobre los requisitos de privacidad de la Ley de Portabilidad y Responsabilidad de los Seguros de Salud (HIPAA, en inglés), las transacciones electrónicas de la Ley HIPAA y la normativa

sobre conjuntos de códigos, así como las normas de seguridad de la Ley HIPAA propuestas, visite el sitio web de los Estados Unidos. Sitio web del Departamento de Salud y Servicios Humanos en: www.hhs.gov/hipaa/index.html.

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

CONSENTIMIENTO:

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

[A CONTINUACIÓN, LA PÁGINA DE FIRMAS]

Página de firmas

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

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

Firma Fecha

Nombre en letra de imprenta

Dirección para la devolución:

[Insertar aquí la dirección local]

ABD CAR Reduction Request

Absent Parent Information

Annuity Issuer Notification

Burial Contract Verification

Providing Verification of Citizenship for Medicaid

What is changing?

Congress passed a new law. Beginning on July 1, 2006, all people who get Medicaid or people who apply for Medicaid must be able to verify that they are U.S. citizens or nationals.

If you are enrolled in Medicare or receive Supplemental Security Income (SSI), or are a "Qualified Alien", you will not be affected by this new law.

What kind of verification do you need?

The best way to verify that you are a citizen is with one of these:

- A U.S. Passport
- A Certificate of Naturalization (DHS Forms N-550 or N-570)
- A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)

(If you do not have any of these items, you will need two documents, one document to show you are a citizen and one document to show who you are.)

You can use any of the following to verify you are a citizen:

- Your birth certificate
- Certification of Report of Birth (DS-1350)
- A Report of Certification of Birth Abroad of a U.S. Citizen (Form FS-240 or FS-545)
- U.S. Citizen I.D. card (DHS Form I-197)
- Adoption Papers
- Military Record showing where you were born
- American Indian Card (I-872)
- Northern Mariana ID Card (I-873)
- Evidence of civil service employment by the U.S. government

You can use any of the following to verify who you are:

- Your picture on your current State driver's license or State ID card
- Your picture on your school ID card
- A U.S. Military ID card
- A Federal, State or Local government ID card with your picture or identifying information such as name, date of birth, sex, height, color of eyes, and address

For individuals under the age 16, verify who you are with:

- School record that shows date and place of birth with parent(s) name

- Clinic, doctor or hospital record showing date of birth
- Daycare or nursery school record showing date and place of birth
- Affidavit signed under penalty of perjury by a parent or guardian (U.S. citizen) attesting to their child's identity (your Case Manager will have the form needed)

What should you do if you don't have any of these things?

- Check with your local county Department of Family and Children Services (DFCS) about other ways to verify you are a citizen and to show who you are
- Tell your local county DFCS why you can't get the verification, and
- Give your local county DFCS any documents you have

Only original document or a copy certified by the Agency that has the original can be used. You cannot use a photocopy of a notarized copy of your document.

How much time do you have to show this documentation to Medicaid?

45 days is the normal time your local county DFCS office may need to work on your application. Check with your local county DFCS office if you need additional time to see exactly how much time you have to get your verification.

What if you still have questions?

If you still have questions, contact your local county DFCS office or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Information is also available on the cms.hhs.gov web site.

Providing Verification of Citizenship for Medicaid (SP)

¿Hay algún cambio?

El Congreso sancionó una nueva ley. A partir del 1 de julio de 2006, todos los beneficiarios de Medicaid o quienes solicitan este sistema deben comprobar que son ciudadanos estadounidenses o residentes naturalizados.

Nota: Esta nueva ley no lo afectará en absoluto si está afiliado a Medicare o recibe las prestaciones de la Seguridad de Ingreso Suplementario (SSI, por su sigla en inglés), o es un 'Inmigrante Calificado'.

¿Qué tipo de constancia necesita?

La mejor forma de comprobar que es ciudadano es presentar uno de los siguientes documentos:

- Un pasaporte estadounidense
- Un Certificado de Naturalización (Formularios N-550 o N-570 del DHS)
- Un Certificado de Ciudadanía Estadounidense (Formularios N-560 o N-561 del DHS)

(Si no tiene ninguno de los documentos enumerados, necesitará dos documentos: uno para comprobar que es ciudadano y el otro para demostrar quién es usted.)

Puede usar cualquiera de los siguientes documentos para comprobar que es ciudadano:

- Su certificado de nacimiento
- Certificación del Acta de Nacimiento (DS-1350)
- Una Constancia de Certificación del Nacimiento en el Extranjero de un Ciudadano Estadounidense (Formulario FS-240 o FS-545)
- Documento de identidad de ciudadanos estadounidenses (Formulario I-197 del DHS)
- Documentos de adopción
- Libreta del servicio militar que indique dónde nació
- Tarjeta para Indios Americanos (I-872)
- Cédula de identidad de las Islas Mariana del Norte (I-873)
- Constancia de un empleo público en alguna oficina del gobierno de EE. UU.

Puede usar cualquiera de los siguientes documentos para demostrar quién es usted:

- Su foto en su licencia de conducir o documento de identidad actualizado del estado
- Su foto en la tarjeta de identificación escolar
- Un documento de identidad del Ejército de los Estados Unidos de Norte América.
- Una cédula de identidad del gobierno federal, de un estado o local con su foto, o datos que permitan identificarlo, tales como nombre, fecha de nacimiento, sexo, altura, color de ojos y direc-

ción

Para los individuos menores de 16 años de edad, demuestre su identidad presentando:

- Una libreta escolar que indique la fecha y el lugar de nacimiento y el nombre de los padres
- Un registro de una clínica, doctor u hospital que indique la fecha de nacimiento
- Una libreta escolar de una guardería o jardín de infantes que indique la fecha y el lugar de nacimiento
- Una declaración jurada bajo penalidad de perjurio firmada por uno de los padres o tutor (ciudadano estadounidense) que certifique la identidad del niño (el encargado de su caso le proveerá el formulario requerido)

¿Qué debe hacer si no tiene ninguno de estos documentos?

- Consulte con la oficina del Departamento de Servicios para Familias y Niños (DFCS, por su sigla en inglés) de su condado sobre otras formas de comprobar su ciudadanía y demostrar su identidad.
- Informe a la oficina del DFCS de su condado porqué no puede conseguir una constancia y entréguele los documentos que tenga en su poder.

NOTA: Sólo se puede usar un documento original o una copia certificada por la Oficina que conserva el original; no puede usar una fotocopia de una copia protocolizada de su documento.

¿Cuál es el plazo de presentación de esta documentación a Medicaid?

La oficina del DFCS de su condado suele tardar unos 45 días en procesar su solicitud; consulte con la oficina si necesita más tiempo para saber exactamente cuál es el plazo para conseguir sus constancias.

¿Qué sucede si aún tiene dudas?

Si aún tiene alguna duda, comuníquese con la oficina del DFCS de su condado o llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios del servicio TTY deben llamar al 1-877-486-2048. También se puede obtener información visitando el sitio web cms.hhs.gov.

Foster Care Worker Card

Disabilities Fact Sheet

What is GMWD?

Georgia Medicaid for Workers with Disabilities (GMWD) provides new options for people with disabilities who are working, or are interested in returning to the workforce, the opportunity to buy health care through Georgia Medicaid. GMWD offers State Medicaid Plan coverage to working age people who have a disability that is permanent but stable and have a desire to return to work.

Why a GMWD?

GMWD establishes a public policy that encourages work. Many people with disabilities can work at least part time, earn money and pay taxes. Generally, people are healthier - both physically and mentally – when they have meaningful, productive lives. An equally important but often overlooked benefit is that a GMWD program can allow people to save money. GMWD will exempt Medical Savings Accounts and approved Independence Accounts to enable an individual to save for adaptive equipment such as a life-equipped vehicle or overhead lift system.

What are the eligibility requirements?

- Be a Georgia Resident and meet the Citizenship requirements for Medicaid.
- You are at least 16 years of age and under age 65.
- You are disabled based on the SSA definition of disability.
- You have earned income from employment or self-employment.
- You have disability income between $600 and $699/mo.
- You have countable income less than 300% of the Federal Poverty Level (FPL) based on your family size.
- Your resources or assets are less than $4000 for an individual or $6000 for a couple.

How much does GMWD cost?

Depending on an individual's age and income, a premium payment may be required for this health care coverage. GMWD premiums are based on a three tier step. Individuals under age 18 and individuals with countable income less then 150% of the FPL are not required to pay a premium. The minimum monthly premium for individuals with countable income of 150% of the FPL or greater is $35.

What services does GMWD cover?

GMWD provides the same services as other "full Medicaid" categories of assistance. Family coverage is not available.

For more information: Contact the Department of Community Health at 404-651-9982.

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IME Pricing Document

Use the Pricing Document only if you receive a Form 942 (Incurred Medical Expense) on an A/R who has to pay a cost share or patient liability amount. The Document is a list of medical services not covered by Medicaid. The cost share or patient liability amount may be adjusted to allow for non-covered services only.

Only adjust the cost share or patient liability for a non-covered service that is prescribed by a doctor or dentist. Refer to the Form 942 for verification.

Do not adjust the cost share or patient liability for a service that would have been paid by Medicaid had the A/R used a Medicaid-participating provider. Medicaid does not pay non-participating providers for a covered service. Refer to the Form 942 for verification.

When you receive a Form 942 on an A/R, use the Pricing Document to determine if the service is non-covered. If you think that the Pricing Document does not provide you the information that you need for a particular Form 942, submit the Form 942 to the Department of Community Health for review. Attach the IME Query form to the Form 942 and mail to the address on the IME Query form.

Medical services **not** covered by Medicaid for adults, age 21 and older are:

- routine dental services (tooth extractions are covered),
- complete and partial dentures,
- prescription eyeglasses, and
- hearing aids.

Refer to the listing of these services for the maximum amount to allow as an income deduction. **If the medical care provider charges less than the maximum amount listed in the Document, allow the lesser of the two amounts**.

Eyeglasses

Item	Maximum Allowed
eye exam/office visit (determine refractive state)	$41
eyeglass frames	$35
bifocal lenses	$45
monofocal lenses	$25
fitting of bifocals (dispensing of)	$34
fitting of monofocals	$28

Hearing Aids

Item	Maximum Allowed
Hearing Aid	$833
Hearing Aid, Programmable	$1193

Item	Maximum Allowed
Earmold, Hearing Aid, Not Disposable, (custom filled, per ear mold, 12/yr.)	$45
Repairs/Labor	$45
Batteries, Hearing Aid (1 pkg. per month)	$5
Hearing Aid Supplies/Accessories: garment - 2/yr.	$23
Hearing Aid Supplies/Accessories: cord - 6/yr.	$10

Home Health Care and Supplies (for the CCSP COA's only)

Item	Maximum Allowed
Incontinence Care (diapers, pads and briefs)	allow actual cost
Liquid Nutritional Supplements (i.e. Ensure)	allow actual cost
Over-the-Counter Medical Supplies	allow actual cost

Prescription Drugs

Most categories of prescription (legend) drugs are covered services through the Medicaid pharmacy program. There are very few categories of non-covered drugs. Only non-covered drugs are allowed as an income deduction.

Below are the categories of drugs not covered for adults, thus, can be allowed as an income deduction from liability or cost share:

- prescription (legend) cough and cold medications,
- over-the-counter drugs, if prescribed by doctor (note: this applies only to the CCSP COA) and
- vitamin and mineral supplements, if prescribed by doctor (note: this applies only to the CCSP COA).

Vitamin/mineral supplements and OTC drugs are not allowed as income deductions for A/R's in nursing homes or institutional hospice as the nursing home or hospice provider is to provide these drugs at no cost to the A/R.

Prescription Cough and Cold Drugs

Allow the full cost of these non-covered drugs as given on the Form 942. The Form 942 must be completed in full and signed by the pharmacist dispensing the drug. An incomplete Form 942 must be returned for proper completion.

Vitamin/Mineral Supplements and OTC Drugs (CCSP A/R's Only)

Allow the full cost of these non-covered drugs as given on the Form 942. The Form 942 must be completed in full and signed by the pharmacist in the store selling the OTC's and the vitamin/mineral supplements. The Form 942 is needed to confirm a doctor's prescription for the items, as well as all other information needed.

Important Information on Medicaid Drug Coverage

Some Medicaid-covered drugs require prior approval before Medicaid pays. Drugs denied for prior approval may be reconsidered for payment if the doctor appeals the denial. Also, the doctor usually can prescribe a different drug with the same therapeutic effect, which can be paid through the Medicaid pharmacy program.

1. **If the pharmacist's response to item #3 on the Form 942 is "Yes," do not allow the cost of the drug as an income deduction for liability or cost share.**
2. **If the pharmacist's response to item #4 on the Form 942 is "Yes," do not allow the cost of the drug as an income deduction for liability or cost share.**

Nursing Home Services

Do not allow the cost of items or services listed below as an income deduction from patient liability. These services are paid to the nursing home through the daily Medicaid reimbursement rate (per diem). Some of the services include but are not limited to:

- liquid nutritional supplements,
- over-the-counter drugs (OTC's), such as antidiarrheals, antacids, analgesics (i.e. aspirin, ibuprophen, acetaminophen), artificial tears, skin ointments, bandages and other such items,
- over-the-counter laxatives and stool softeners,
- incontinency care items, such as pads, diapers, special mattresses, and
- durable medical equipment, such as wheelchairs, walkers, lifts, beds.

An A/R or the A/R's family may choose to pay for certain medical items or services out of personal preference rather than medical necessity. Examples include a private duty nurse, a private room or bed-hold days. Do not allow the cost of personal preference items or services as an income deduction from patient liability.

Physician and Psychiatric Services

Submit the completed Form 942 for a physician service to the Department of Community Health for a decision regarding allowing the cost of the service.

Podiatry and Orthopedic Services

Submit the completed Form 942 for a podiatry or orthopedic service to the Department of Community Health for a decision regarding allowing the cost of the service.

Psychological Services

Service	Maximum Allowed
Psychological Diagnostic Interview / Evaluation / Testing	$62 per 1 hour unit
Individual or Family Psychotherapy	$53 per ½ hour unit
Group Psychotherapy	$29 per ½ hour unit

Dental Services

Full-Mouth Radiographs			
D0210	Full-Mouth Series	(EPSDT ONLY)	$72.45
Individual Periapical Radiographs		"	
D0220	Periapical, One Film	"	$13.45
D0230	Periapical, each additional film	"	$10.35
Occlusal Radiographs		(EPSDT ONLY)	
D0240	Occlusal Film, one film	"	$19.66
Individual Bitewing Radiographs		"	
D0270	Bitewing, One Film	"	$14.49
D0272	Bitewing, Two Films	"	$21.73
D0274	Bitewing, Four Films	"	$33.12
Diagnostic and Clinical Examinations and Services			
D0150	Comprehensive Oral Evaluation	(EPSDT ONLY)	$39.33
D0120	Periodic Oral Evaluation		$ 22.77
Amalgam Restorations (Including local anesthesia, base and polishing)			
D2140	Permanent, One Surface	"	$60.03
	Primary	"	$53.82
D2150	Permanent, Two Surfaces	"	$77.62
	Primary		$69.34
D2160	Permanent, Three Surfaces	"	$94.18
	Primary		$82.80
D2951	Pin Retention (exclusive of restoration)	"	$28.98
D2999	Endo Post	"	$54.22
Acrylic and Composite Restorations			
D2330	Composite - One Surface-Anterior	"	$71.41
D2331	Composite - Two Surfaces-Anterior	"	$91.08
D2332	Composite - Three or More Surfaces - Anterior	"	$110.74
D2951	Composite, Pin Retained	(EPSDT ONLY)	$28.98
D2391	Composite - One Surface Posterior - Primary	"	$80.73
D2391	Permanent	"	$88.80
D2392	Composite - Two Surface Posterior - Primary	"	$95.22
D2392	Permanent		$110.74

D2394	Composite – Four More Surfaces - Primary	"	$126.37
D2394	Permanent		$151.42
Crowns			
D2932	Plastic, Acrylic, Performed, or Composite Crown	"	$176.98
D2930	Stainless Steel, primary tooth open-face stainless steel crown with composite or acrylic facing	"	$143.86
D2931	Stainless Steel, permanent open-face stainless steel crown with composite or acrylic facing	"	$162.49
Other Restorative Services			
D2970	Fracture of Tooth - Composite Build-up	"	$154.21
D2920	Re-cement Crowns	"	$41.40
D2940	Sedative Fillings	"	$54.85
Endodontic Services		(EPSDT ONLY)	
D3220	Pulpotomy	"	$90.04
Root Canal Therapy			
D3310	Deciduous (per tooth)	"	$77.64
*D3310	One Canal - Permanent	"	$379.84
D3320	Two Canals - Permanent	"	$463.68
D3999	Emergency - Open Pulp Chamber to Establish Drainage	"	$91.08
Periapical Services		"	
D3410	Apicoectomy - performed as separate surgical procedure	"	$229.81
D3426	Apicoectomy - any and all additional roots	"	$38.06
Periodontal Services			
*D4341	Periodontal Scaling and Root Planning, per quadrant	"	$140.76
*D4210	Gingivectomy or Gingivoplasty, per quadrant	(EPSDT ONLY)	$157.38
*D4220	Gingival Curettage, per quadrant	"	$129.37
*D4260	Osseous Surgery, per quadrant	"	$341.00
D4271	Autogenous Graft	"	$259.84
D4270	Pedicle Graft	"	$272.14
Prosthodontic Services, Removable Complete Dentures			

D5110	Complete Upper	"	$673.78
D5120	Complete Lower	"	$673.78
D5130	Immediate Upper	"	$554.12
D5140	Immediate Lower	"	$554.12
Partial Dentures		"	
D5201	Upper - Acrylic base w/wrought wire clasps	"	$276.64
D5202	Lower - Acrylic base w/wrought wire clasps	"	$276.64
D5211	Upper Partial-Resin Base (Including Any Conventional Clasps, Rests and Teeth)	"	$569.25
D5212	Lower Partial-Resin Base (Including Any Conventional Clasps, Rests and Teeth)	"	$661.36
*D5899	Upper - Acrylic base w/o clasps	"	$184.46
*D5899	Lower - Acrylic base w/o clasps	"	$184.46
Repairs to Dentures			
D5410	Adjustment - Complete Denture Upper	"	$23.77
D5411	Adjustment - Complete Denture Lower	"	$23.77
D5421	Adjustment - Partial Denture Upper	"	$11.76
D5422	Adjustment - Partial Denture Lower	"	$11.76
D5510	Repair broken complete or partial denture - no teeth broken	"	$73.48
D5640	Repair broken complete or partial denture - replace one or more broken teeth	"	$92.17
D5650	Adding tooth to partial denture to replace extracted tooth	"	$92.17
D5660	Adding clasp to existing partial denture	"	$110.74
D5750	Laboratory Relining Upper	"	$156.56
D5751	Laboratory Relining Lower	"	$156.56
D5850	Tissue Conditioning/upper	"	$47.54
D5851	Tissue Conditioning/lower	"	$47.54
*Alveoplasty (Surgical preparation of ridge for dentures)			
*D7310	Alveoplasty in conjunction with extractions/quad	(EPSDT ONLY)	$150.07

D7310	Alveoplasty, less than a quadrant In conjunction with extractions		$54.22
Alveoplasty without extractions			
*D7320	Alveoplasty without extractions, (quadrant)	(EPSDT ONLY)	$669.64
D7320	Alveoplasty less than a quadrant without extractions		$63.86

Surgical Excision

Codes D7971, D7440, D7450, D7451, D7460, D7461, D7471 and D7480 are non-covered for Adults.

D7440	Excision of malignant tumor Lesion diameter up to 1.25cm	"	$843.52
D7450	Removal of benign odontogenic cyst or tumor up to 1.25cm	"	$477.13
D7451	Removal of benign odontogenic cyst or cyst or tumor 1.25cm or larger	"	$750.37
D7460	Removal of benign nonodontogenic cyst or tumor - up to 1.25cm	"	$477.13
D7461	Removal of benign nonodontogenic cyst or tumor – over 1.25cm	"	$769.00
D7471	Removal of exostosis lateral - maxilla	"	$230.55
D7471	Removal of exostosis lateral - mandible	"	$230.55

Other Repair Procedures

*D7960	Frenulectomy (Frenectomy)	(EPSDT ONLY)	$315.67
D7970	Excision of Hyperplasic Tissue (per arch)	"	$324.99
D7971	Excision of Pericoronal Tissue		$85.90

Adjunctive General Services

Unclassified Treatment			
D9110	Palliative (emergency) treatment of dental pain, minor procedure	(EPSDT ONLY)	$51.75
Drugs			
D9610	Chemotherapy - Therapeutic Drug Injection	(EPSDT ONLY)	$53.82

D9630	Other Drugs and/or Medications	(EPSDT ONLY)	$38.29

IV-E Budget Sheet

Letter of Non-Cooperation with DCSS

Level of Care Agreement

Medicaid Review Response

Medically Needy Option Statement

Medicare Buy-In Problem Template

Medicare Savings Programs Request for Information

Non-Emergency Transportation Broker Sheet

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC at 770-570-3373 or toll free at 886-211-0950**.

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free: 1-866-388-9844 Local: 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickins, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb
Central	Southeastrans Toll free: 1-866-991-6701 Local: 404-305-3535	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, Wilkinson

Region	Broker / Phone number	Counties served
East	LogistiCare Toll free: 1-888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, Wilkes
Southwest	Southwest Georgia Regional Development Center Toll free: 1-888-224-7985 (until March 31)	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, Worth

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Non-Emergency Transportation Broker Sheet (Spanish)

¿Cómo obtengo servicios de transporte cuando no sea una emergencia?

Si es recipiente de Medicaid y no cuenta con ninguna otra manera para ir a obtener servicios médicos o servicios que cubre el Medicaid, puede llamar a un coordinador de transporte para que le lleve. En la mayoría de los casos, tiene que llamar con tres días de anticipación para programar el transporte. Las situaciones de atención urgente y unas pocas excepciones se pueden programar con menos anticipación. Cada coordinador tiene un número de teléfono sin cargos para programar servicios de transporte, y está disponible durante los días de semana (lunes a viernes) desde las 7:00 a.m. hasta las 6:00 p.m. Todos los condados de Georgia están agrupados en cinco regiones para propósitos del programa NET. Hay un Coordinador NET para cubrir cada región. Si necesita servicios del programa NET, **tiene que llamar al Coordinador NET correspondiente al condado en que vive** para pedir transporte que no es de emergencia. Vea la tabla a continuación para determinar qué coordinador corresponde a su condado, y llame al teléfono del coordinador para esa región.

¿Qué hago si tengo problemas con un coordinador de NET?

La División de Asistencia Médica (DMA, por sus siglas en inglés) vigila la calidad de los servicios que ofrecen los coordinadores manejando las quejas del consumidor y requiriéndoles informes periódicos a los coordinadores. El Departamento de Auditoría del estado también hace evaluaciones locales de los servicios proporcionados por cada coordinador. Si tiene una pregunta, comentario o queja sobre un coordinador, **llame al CIC para Miembros al 770-570-3373 o sin cargos al 886-211-0950.**

Región	Coordinador / Teléfono	Condados cubiertos
Norte	Southeastrans Sin cargos 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickins, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb
Central	Southeastrans Sin cargos 1-866-991-6701	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, Wilkinson

Región	Coordinador / Teléfono	Condados cubiertos
	Local 404-305-3535	
Este	LogistiCare Sin cargos 1-888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, Wilkes
Suroeste	LogistiCare Sin cargos 1-888-224-7985 (útil Marcha 31, 2007)	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, Worth

Rev. 2/07

Notice of Termination of Medicaid Benefits Due to Contract(s)

(Medicare) Part D Complaint Checklist

PeachCare Special Request

QIT Approved Format Deviation

QIT Approved Template 1

QIT Checklist

Record of Life Insurance Policies

Special Needs Trust Routing

TEFRA/Katie Beckett Cover Letter

TEFRA/Katie Beckett Cover Letter (Sp)

TEFRA/Katie Beckett Worksheet

Undue Hardship Waiver Letter

Women’s Health Medicaid Physician’s Statement of Treatment