OSAH FORM 1

OSAH USE ONLY:	AGENCY DFCS-M	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE

DHS, DIVISION OF FAMILY & CHILDREN SERVICES
MEDICAID

Applicant/Recipient's County of Residence:	Date Hearing Request Filed with Agency:	Agency Case Number:

Check here if an application was DENIED: ☐
Check here if benefits were REDUCED/TERMINATED: ☐
Check here if the LEVEL OF ASSISTANCE is disputed: ☐
Check here if A/R requires notice of hearing in SPANISH: ☐

Check Only One:

AGED, BLIND, OR DISABLED (ABD) REFERRALS

- ☐ ABDMN (ABD Medically Needy: § 2150)
- ☐ CCSP (Community Care Services Program: § 2131)
- ☐ DAC (Disabled Adult Child: § 2115)
- ☐ FSSIDC (Former SSI Disabled Child: § 2116)
- ☐ HOSPICE (Hospice Medicaid: § 2135)
- ☐ HOSPITAL (Hospital Medicaid: § 2137)
- ☐ ICWP (Independent Care Waiver Program: § 2139)
- ☐ KATIE (TEFRA/Katie Beckett: § 2133)
- ☐ LIS (Low Income Subsidy (Extra Help for Medicare Part D): § 2146)
- ☐ NH (Nursing Home: § 2141)
- ☐ NOW/COMP (New Options Waiver/Comprehensive Supports Waiver Program: § 2132)
- ☐ PICKLE (PL 94-566; Pickle: § 2113)
- ☐ PROTEC (Protected Medicaid 1972: § 2123)
- ☐ QDWI (Qualified Disabled Working Individuals: § 2147)
- ☐ QI1 (Qualifying Individuals-1: § 2145)
- ☐ QMB (Qualified Medicare Beneficiaries: § 2143)
- ☐ SLMB (Specified Low-Income Medicare Beneficiaries: § 2144)
- ☐ SSI (SSI Medicaid: § 2111)
- ☐ WID01 (Disabled Widow(er): § 2117)
- ☐ WID02 (Disabled Widow(er) 60-64: § 2119)
- ☐ WID03 (Widow(er) 1984: § 2121)

FAMILY MEDICAID REFERRALS

- ☐ 4MEX (Four Months Extended Medicaid: § 2170)
- ☐ CU19 (Children Under 19 Years of Age: § 2182)
- ☐ FMN (Family Medicaid Medically Needy: § 2196)
- ☐ NEWBORN (Newborn Medicaid: § 2174)
- ☐ PCWC (Parent/Caretaker with Children: § 2162)
- ☐ PREG (Pregnant Women: § 2184)
- ☐ P4HB (Planning for Healthy Babies: § 2186)
- ☐ TMA (Transitional Medical Assistance: § 2166)
- ☐ WHM (Women's Health Medicaid: § 2198)
- ☐ PATH (Georgia Pathways: §§ 2195, 2256)

CHILDREN IN PLACEMENT REFERRALS

- ☐ AAM (IV-E Foster Care Medicaid: § 2817)
- ☐ CHAFEE (Chafee Independence Program Medicaid: § 2818)
- ☐ CWFC (Child Welfare Foster Care Medicaid: § 2890)
- ☐ FFC (Former Foster Care Medicaid: § 2819)
- ☐ FOST (IV-E Foster Care Medicaid: § 2815)
- ☐ SAAM (State Adoption Assistance Medicaid: § 2895)

OTHER REFERRALS

- ☐ EMA (Emergency Medicaid Assistance: § 2054)
- ☐ PEM (Presumptive Eligibility Medicaid: § 2067)
- ☐ RETRO (Retroactive Medicaid: § 2053)
- ☐ OTHER, specify:

APPLICANT/RECIPIENT

NAME	TEL #:	FAX #:
CURRENT ADDRESS INCLUDING ZIP CODE:		EMAIL:
ATTORNEY'S NAME (IF APPLICABLE)	TEL #:	FAX #:
ADDRESS INCLUDING ZIP CODE	GEORGIA BAR #:	EMAIL:
PERSONAL REPRESENTATIVE'S NAME (IF APPLICABLE)	TEL #:	FAX #:
CURRENT ADDRESS INCLUDING ZIP CODE	RELATIONSHIP TO A/R:	EMAIL:

LOCAL DFCS OFFICE

NAME OF OFFICE:	TEL #:	FAX #:
ADDRESS INCLUDING ZIP CODE:	CASEWORKER'S NAME: CASEWORKER'S DIRECT TEL #: EMAIL:	SUPERVISOR'S NAME: SUPERVISOR'S DIRECT TEL #: EMAIL:
REGIONAL HEARING COORDINATOR (NAME AND ADDRESS):	COORDINATOR'S DIRECT TEL #:	FAX #: EMAIL:

***** COPIES OF ADVERSE ACTION LETTER AND HEARING REQUEST MUST BE ATTACHED*****