Georgia Department of Human Services
Division of Family and Children Services
Medicaid Notification Form SSI Status Change

To: Social Security Administration Date _____

_____

_____

From: Georgia Dept Human Services Case Worker Phone _____

_____

_____

Recipient Information

Recipient Name _____ SSN _____

Address _____ Phone Number _____

_____ Case Number _____

Please accept the change(s) shown below for the above-named SSI recipient

____ Special Needs Reduction Amount: $ _____ Date of Change _____

____ Paying Less for Personal Care

____ No Longer Pays for Personal Care Attendant

____ Not Furnishing Food for Personal Care Attendant

____ Payments For Personal Care Attendant Could Not Be Verified

____ Needs Of Ineligible Spouse Removed from Recipient's Budget

____ Recipient Institutionalized Date Admitted _____

Type of Institution: _____ Title XIX Institution _____ Other Institution

Name of Institution _____

Institution Address _____

____ Change of Address Date of Change _____

Previous Address _____

____ Recipient Deceased Date of Death _____

____ Change in Income or Resources Date of Change, if known _____

New Income or Resource _____

Comments
