

Georgia Department of Human Services  
IV-E Eligibility Documentation Sheet

Child's Name:

AU#:

Medicaid #:

P

Check one:  Initial Decision

Review due MM/YYYY

Interim Change

Court Order Language:

Foster Care Placement:

Age:

Citizen/Alienage:

Living with a Specified Relative & Removal Household:

Parental Deprivation:

Family Resources & Income: (complete Form 239)

AFDC Relatedness Criteria Met?

Child's Resources & Income: (complete budget)

Comments:

1. Eligibility Month: \_\_\_\_\_ IV-E Eligible:  YES  NO IV-E Eligible/SSI only:

2. IV-E criteria not met, check all that apply: Court order language  Court order timeliness   
Age  Income/Resources  Deprivation  Citizenship/Alienage  Specified Relative/Removal home

3. IV-E Reimbursable:  YES  NO Begin Date: \_\_\_\_\_ End Date (if applicable): \_\_\_\_\_

4. If not reimbursable, check all that apply: IV-E language  Custody  SSI  Age   
Unapproved Placement  Income/resources  Deprivation  Relative Placement

5. Medicaid Eligibility:  YES  NO Class of Assistance: \_\_\_\_\_

MES Signature:

Date:

Printed name of MES: \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

*Note: Court Order Language, Foster Care Placement, Age, Parental Deprivation & Child's Income/Resources ONLY must be completed at review*