**Georgia Department of Human Services**
**Division of Family and Children Services**
**Notification of Eligibility – Emergency Medicaid Assistance Program**

## Important information

**You have applied for Emergency Medicaid Assistance (EMA) benefits. If you are determined to be eligible, you will receive an approval letter which includes your Medicaid certification for the dates Medicaid coverage was granted for the emergency service(s). The dates of certification were determined during the eligibility process from information provided by your attending medical provider. It is important to note that final determination of whether a medical service meets the definition of emergency care is made by Alliant Health Solutions (AHS).**

**Emergency services** are those that are:

- Medically necessary, and
- Result from the sudden onset of a health condition with acute symptoms (including emergency labor and delivery), and
- Which, in the absence of immediate medical attention, are reasonably likely to result in at least one of the following:
  - Placing the individual's health in serious jeopardy, or
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part.

Only services that fully meet the federal definition of an emergency medical condition will be covered beginning January 1, 2006. Not all services that are medically necessary meet this definition. Certain types of care provided to chronically ill persons are beyond the intent of federal law and are not considered emergency services. Such care includes alternate level of care in a hospital, nursing facility services, home care and personal care.

**Only emergency services determined to meet the Federal definition of an emergency as determined by AHS are covered. Any services provided after the emergency condition is stabilized are not payable. Your provider can bill you for services which are not determined to be emergencies.**

**All the information that I have provided is true and complete as far as I know.**

By signing this form below, I acknowledge that I understand that only those claims which meet the Federal definition of an Emergency as determined by the Alliant Health Solutions may be paid by the Medicaid program.

______________________________ ____________________
Applicant Signature Date

______________________________
Applicant Printed Name