Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

(QMB - payment of premiums, coinsurance, and deductibles;

SLMB - payment of Part B premium; **and QI-1** - payment of Part B premium**)**

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:**

   _____County DFCS

   (Mail or deliver application _____

   _____ to the DFCS office in your _____

   _____ county of residence)

   _____

   ATTN: _____
3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.
5. **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).**

PERSONAL INFORMATION: You may have someone help you complete this

application.

Applicant's Name (Last, First, Middle Initial) Mailing Address	If you wish to name a person to act on your behalf, complete the information below: Representative's Name (Last, First, Middle Initial)
Street Address	Mailing Address
City State Zip Do you own/are you purchasing home? □ Y □ N	City State Zip
Phone County E-Mail Address	Phone E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual
E-mail Communication: Yes or No___ (optional)* Texting: Yes_ or No__(optional)*	E-mail Communication: Yes or No___ (optional)* Texting: Yes_ or No__(optional)*
What is your Preferred Language? If an interview is required, will you need an interpreter? Yes___or No	What is your Preferred Language? If an interview is required, will you need an interpreter? Yes___or No

*You have the option to choose how you would like to receive notifications about your information. If you choose to receive email or text notifications, you will receive a message notifying you that you have a notice in My Notices located in GA Gateway Customer Portal. For Email Communication, you must provide us with your email address and accept the terms and conditions for paperless notices located in GA Gateway Customer Portal after you create an account. Please visit the GA Gateway Customer Portal Website at www.gateway.ga.gov to update your notification settings.

For Texting Communication, you must provide us with your phone number. Standard message and data rates may apply. This may vary by carriers, please check with your provider.

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Maiden/other name(s):	Birthdate	Sex	Race	U.S. Citizen (Yes or No)	Social Security Number	Marital Status
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? □ **Yes** □ **No**

Are you blind or disabled? □ **Yes** □ **No -** Is your spouse blind or disabled?

□ **Yes** □ **No**

For the Applicant:

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable): Do you have a disability that will require a Reasonable Modification or Communication Assistance? Yes_____No _____ (If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting): Sign Language interpreter __; TTY ; Large Print _____; Electronic communication (email) _; Braille __; Video Relay __; Cued Speech Interpreter ; Oral Interpreter _; Tactile Interpreter __; Telephone call reminder of program deadlines _; Telephonic signature (if applicable) _____; Face-to-face interview (home visit) _____;

Other:_____

Do you need this Reasonable Modification or Communication Assistance one- time ___or ongoing __? If possible, briefly explain when and how long you need this modification or assistance?

For Authorized Representatives:

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance

for Authorized Representatives (if applicable):

Does the authorized representative have a disability that will

require a Reasonable Modification or Communication Assistance?

Yes_____No ___(If

yes,

please describe the Reasonable Modification or Communication Assistance that you are requesting):

Sign Language interpreter ____; TTY _____; Large Print _ _____; Electronic communication (email) _; Braille _____ _____; Video Relay _____; Cued Speech Interpreter__; Oral Interpreter ___; Tactile Interpreter _____ _____; Telephone call reminder of program deadlines __; Telephonic signature (if applicable) __; Face-to-face interview (home visit) ___; Other: _

Does the authorized representative need this Reasonable Modification or Communication Assistance

one-time __or ongoing __? If possible, briefly explain when and how long you need this modification or assistance?

_____

LIVING ARRANGEMENT: Check the box(es) that best describes your current situation.

Living In Own Home	Nursing Facility	Another's Home	Hospice	Hospital	Katie Beckett	Community Care	Assisted Living	Other/ Renting
	Date Admitted:			Date Admitted:		Date Admitted:		

HEALTH INSURANCE:

Do you have Medicare? □ **Yes** □ **No** Are you enrolled in a Medicare HMO or Medicare Drug program? □ **Yes** □ **No**	Type of Coverage □ **Part A** □ **Part B** (hospital) (doctor) **Part C** **Part D** (Advantage) (RX)	Effective Date: _____ Medicare Number: _____	Have you ever received SSI? □ **Yes** □ **No** If so, when did it end? _____
Does your spouse have Medicare? □ **Yes** □ **No**	Type of Coverage □ **Part A** □ **Part B** □ **Part C** □ **Part D**	Effective Date: _____ Medicare Number: _____	Has your spouse ever received SSI? □ **Yes** □ **No** If so, when did it end? _____

Do you have other health insurance? □ **Yes** □ **No**

Does your spouse have other health insurance? □ **Yes** □ **No**

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name,	Type of Coverage (Hospital, Medicare	Effective	Policy Number

			Date	
	Address, and Telephone Number	Supplement, Drugs, Major Medical,)		
Self				
Spouse				

REAL PROPERTY: Do you own all or part of any real estate in which you do not

live? □ **Yes** □ **No**

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.? □ **Yes** □ **No** If yes, please complete

the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account □ **Yes** □ **No** Funeral plans/ prepaid burial item □ **Yes** □ **No** Savings account □ **Yes** □ **No** Burial plots or contracts □ **Yes** □ **No**

Government bonds □ **Yes** □ **No** Stocks and bonds □ **Yes** □ **No**

Trust funds □ **Yes** □ **No** Other (IRA, CD, promissory note, etc.) □ **Yes** □ **No**

Have you or your spouse given away any assets for less than its value?

□ **Yes** □ **No**

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, etc.

Do you or your spouse have a life insurance policy? □ **Yes**

□ **No**

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receive. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security SSI Wages/ Self- Employment

Railroad Retirement Benefits Veterans' Benefits Trust or Annuity Payments Pensions/ Retirement Benefits Rental Income Paid to You Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)

Are you a veteran? □ **Yes** □ **No** Is your spouse a veteran? **Yes** **No**

Where did you and spouse work in the past?

_____

Do you or your spouse have any unpaid medical bills? □ **Yes** □ **No**

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of

confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying 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 below, as a condition of his or her eligibility for the benefits covered by this application.)

As a condition of my eligibility, 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.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I

agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, disability, religion, or national origin. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I understand that Medicaid members who, at the time of death, were inpatients in a nursing facility, intermediate care facility for the individuals with intellectual disabilities, or other medical institution and have their medical care paid by Medicaid will be subject to the Medicaid Estate Recovery Program.

I understand that Medicaid members who, at the time of death, were 55 years of age or older are subject to the Medicaid Estate Recovery Program but only for medical services consisting of nursing facility services, personal care services, home and community based services, and hospital and prescription drug services provided to

Members in nursing facilities or receiving home and community based services when they received home and community-based services or are enrolled in and receive services through a waiver program. I

acknowledge receipt of a written notice that medical assistance payments made on my behalf may be recovered from my estate after my death.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application, and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**

Signature of Applicant's Spouse or Representative:	**Date:**
Print the name of the Applicant or Representative:	**Relationship to the Applicant:**
Print the name of the Applicant's Spouse or Representative:	**Relationship to the Applicant's Spouse:**

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to

apply to register to vote here today?

_____Yes

_____No

_____I do not want to answer the Voter Registration question

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at 2 Martin Luther King Jr. Drive, Ste. 802, West Tower, Atlanta, GA 30334 or by calling (404) 656-2871.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration

application from your caseworker. If you complete a Voter Registration application, submit it to the

Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.

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

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 (404) 657-3433 or DCH 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

https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form at the DCH Katie Becket

(KB) Team office or online at https://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, Ste. 19-454, Atlanta, GA 30303, (404) 657-3735. 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.

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 https://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.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the 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 Human Services (DHS)** policy, 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, Ste. 19-454, Atlanta, GA 30303, (404) 657-3735. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, Ste. 29-103, Atlanta, GA 30303, or call (404) 657-5244.

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.

Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, or religion.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied

for benefits. Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue SW, Washington, D.C. 20201, or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Any person or representative for a Katie Beckett applicant or participant may file a verbal or written complaint alleging unlawful discrimination by contacting the DCH Civil Rights Coordinator, Policy, Compliance and Operations Office, Medical Assistance Plans Division, DCH at (local) 404-967-0401, or via email to DCH.CivilRights@dch.ga.gov, or via U.S. mail to:

The Georgia Department of Community
Health DCH Civil Rights Coordinator
Policy, Compliance and Operations Office
Medical Assistance Plans Division
2 Peachtree Street, NW
37th Floor

Atlanta, GA 30303