Georgia Department of Human Services
Facility Action Request

Date: _____

To: _____, Administrator/Case Manager

_____
Facility

From: _____, MAO Eligibility Worker

_____
County Department of Family and Children Services

_____
Street or P.O. Box

_____
City State Zip

Re: _____
Resident

( ) We are returning the enclosed form(s) on the above named resident:

□ DMA 6 □ DMA 59 □ CCSP 5590 □ CCSP 5588

□ MRWP Communicator □ ICWP Communicator □ Hospice Communicator

We have no record of the resident as a Medicaid recipient, nor do we have an application for Medical Assistance (Medicaid) on file. As you know, we cannot authorize a vendor payment/cost share until Medicaid eligibility has been established.

If this resident needs Medicaid, please request the responsible party to file an application with our office. We will request that you resubmit the enclosed form(s) when an application is filed.

( ) We have taken an application for Medicaid for the above named resident of your facility, but as yet have not received the following form(s) from you:

□ DMA 6 □ DMA 59 □ CCSP 5590 □ CCSP 5588

□ MRWP Communicator □ ICWP Communicator □ Hospice Communicator

Please submit the necessary form(s) so that we may complete the determination of eligibility for this applicant.

Thank you for your cooperation in this matter.