Georgia Department of Human Services
Katie Beckett Cover Letter

RSM/Katie Beckett County Department of Family and Children Services

RE: ______________________________ ______________
Date

______________________________ ______________
AU Number

______________________________ ______________
MES Name

______________________________ ______________
Telephone Number

Enclosed is a packet of forms to be completed for an application or review for the Katie Beckett Medicaid Class of Assistance. Please read all the information contained herein and complete the forms EXACTLY as outlined. Should you have problems or questions, contact the Medicaid Eligibility Specialist (MES) at the telephone number provided above. The packet of forms should include the following as checked below:

- ☐ Medicaid Application, Form 700, (answer questions as if your child was completing)
- ☐ Verification Checklist, Form 981
- ☐ Pediatric DMA-6(A), Physician's Recommendation for Pediatric Care
- ☐ Pediatric DMA-6(A) Instructions
- ☐ TEFRA/Katie Beckett Medical Necessity level of care statement, DMA Form 706
- ☐ TEFRA/Katie Beckett Medical Necessity level of care statement, Instructions
- ☐ TEFRA/Katie Beckett Cost-Effectiveness Form, DMA Form 704
- ☑ Other Therapy Notes

F218 Enclosed
F285 Enclosed

Please return the completed information to DFCS by ____________________.
If you need an extension, please contact case worker by the above due date.

We will consider this application without regard to race, color, sex, age, disability, religion, national origin or political belief.

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept

Check block(s) that apply to you:
- ☐ Pregnant Woman
- ☐ Families w/Children – LIM
- ☐ Child(ren) Only – RSM
- ☐ Chafee Independence Program Medicaid

KB Application

Were you in foster care on your 18th birthday? ☐ Yes ☐ No In which state? ______

PLEASE NOTE: A Face to Face interview is not required for Medicaid applications. Please answer all questions as completely and accurately as possible. If you cannot understand or complete this application, please notify DFCS staff and assistance will be provided free of charge.

Your Name: (Please Print) FIRST	M.I.	Last	Maiden (if applicable)	Today's Date:	
Mailing Address:			City:	State:	Zip Code:
Residence Address (if different from Mailing Address):			Phone Number(s):	E-mail Address:	

Please list all persons living with you for whom you want Medicaid. List yourself if you want Medicaid for yourself.

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Social Security Number	Is this Person a U.S. Citizen? (Y/N) (you may qualify for Medicaid even if you answer No)	Does the Father of this child live in your home? (Y/N)	Does the Mother of this child live in your home? (Y/N)

Please list all persons living with you for whom you DON'T want Medicaid. List yourself if you don't want Medicaid. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid. If provided, we will use the SSN for computer matches with other agencies and it may help us process your child's application. We will NOT share your information with the Department of Homeland Security (formerly the INS).

Is anyone in the household pregnant? ☐ Yes ☐ No If yes, who is pregnant? ______________ Due Date: ________ Please attach verification of pregnancy if available.

Do you have any unpaid medical bills from the past three months? ☐ Yes ☐ No If yes, which months? ______________

Does anyone in your household have Health Insurance? ☐ Yes ☐ No If yes, list Insurance Company and policy number:

Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? ☐ Yes ☐ No If yes, have you received Women's Health Medicaid previously? ☐ Yes ☐ No

INCOME, RESOURCES and DEPENDENT CARE

List all income received by persons on page 1 of this application. Be sure to show the amount before deductions. Attach an extra sheet if necessary. We will decide, based on the type of Medicaid, whose income must be counted and whose may be excluded. **If you are applying for Children Only or Pregnant Woman Medicaid, you do not have to complete the Resources/Vehicles sections below.**

Income	Gross Amount per Pay Check (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving
Wages/Earnings			
Current Employer:			
Wages/Earnings			
Current Employer:			
Social Security Income/SSI			
Worker's Compensation			
Pensions or Retirement Benefits			
Child Support/ Contributions			
Unemployment Benefits			
Other Income, please specify:			

Resources	Amount in Account/Value	Who Owns Resource?
Cash		
Checking Account		
Savings Account		
Credit Union		
401K/Retirement Account		
Other		

Vehicle(s): Cars, trucks, motorcycles (licensed)

Make	Model	Year	Amount Owed?

Do you pay for dependent care (daycare for a child or care for an adult who cannot care for himself/herself) so that someone in your household can work?

Name of Parent who works	Name of child or adult cared for	Name of care provider	Amount of Payment	How Often? (weekly, 2-weeks, monthly, etc)

If you are applying for Medicaid for children and one or both of their parents are not in the home, please provide the following information:

Child's Name	Absent Parent's Name (Mother/Father)	Do they have Medical Coverage on the Child? Yes/No	If Yes to Medical Coverage, please list name of insurance company & group number

I understand that this information may need to be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be obtained to verify and determine eligibility for Medicaid. I agree to assign to the state all rights to medical support and third party support payments (hospital and medical benefits). I agree to give the State the right to require an absent parent provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do **not** cooperate, I understand I may lose my Medicaid benefits, and only my children will receive benefits unless good cause is established. I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.

☐ I certify under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States. If I am a parent or legal guardian, I certify that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States. ☐ I certify to the best of my knowledge and belief that the person(s) for whom I am applying for Medicaid is/are U.S. citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge.

Signature (Required): ______________________ Date: ______________

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

I understand that the Ga. Division of Family and Children Services may require verification from the United States Department of Homeland Security of my/my children's citizenship or immigration status when seeking benefits. Information received from DHS may affect my/my children's eligibility.

Please fill out and sign **ONE or BOTH** of the following statements as it pertains to the status of each person seeking benefits.

CHILDREN SEEKING BENEFITS

Name	Place of Birth (city,state,country)	U.S. Citizen (Check whichever applies)	Lawfully Admitted Immigrant (Check whichever applies)	Date Naturalized or Admitted into U.S. (If applicable)

I, ____________________ attest to the identity of the child/children listed above and
(PRINT NAME)
certify under penalty of perjury, that the information written and checked above is true.

____________________ ____________________
SIGNATURE (PARENT/GUARDIAN) (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth (city,state,country)	U.S. Citizen (Check whichever applies)	Lawfully Admitted Immigrant (Check whichever applies)	Date Naturalized or Admitted into U.S. (If applicable)

I, ____________________ certify under penalty of perjury, that the information written and checked above is true.
(PRINT NAME)

____________________ ____________________
SIGNATURE (PARENT/GUARDIAN) (DATE)

____________________ ____________________
SIGNATURE (PARENT/GUARDIAN) (DATE)

Type of Program: ☐ Nursing Facility
☐ GAPP
☐ TEFRA/Katie Beckett

PEDIATRIC DMA 6(A)

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:
Name: ____________________
Address: ____________________
____
DFCS County: ____________________

2. Medicaid Number: ____________________

3. Social Security Number

4. Sex Age 4A. Birthdate

5. Primary Care Physician: ____________________

6. Applicant's Telephone # ____________________

7. Does guardian think the applicant should be institutionalized? ☐ Yes ☐ No

8. Does child attend school? ☐ Yes ☐ No

9. Date of Medicaid Application ____/____/____

Name of Caregiver #1: ____________________ Name of Caregiver #2: ____________________

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Georgia Department of Community Health and the Department of Human Services, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature: ____________________ 11. Date: ____/____/____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

13. Diagnosis	1. ICD	2. ICD	3. ICD
1) ____________ 2) ____________ 3) ____________ *(Add attachment for additional diagnoses)*			

14. **Medications**				15. **Diagnostic and Treatment Procedures**	
Name	Dosage	Route	Frequency	Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations: ____________ Rehabilitative Services: ____________ Other Health Services: ____________

Hospital Diagnosis: 1) ____________ 2) Secondary ____________ 3) Other ____________

17. Anticipated Dates of Hospitalization: ____________

18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation:
☐ Initial
☐ Change Level of Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☐ Lives at home

21. Length of Time Care Needed ____ Months
1) ☐ Permanent
2) ☐ Temporary________estimated

22. Is patient free of communicable diseases?
☐ Yes ☐ No

23. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print): ____________________

Physician's Address (Print): ____________________

25. I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital

____________________ **Physician's Signature**

26. Date signed by Physician ____/____/____

27. Physician's Licensure No. ____________________

28. Physician's Telephone #: ____________________

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral S tatus
☐ Regular	☐ Age Dependent Incontinence	☐ Monitoring	☐ Prosthesis	☐ Agitated
☐ Diabetic Shots	☐ Incontinent - Age > 3 years	☐ CPAP/Bi-PAP	☐ Splints	☐ Cooperative
☐ Formula-Special	☐ Colostomy	☐ CP Monitor	☐ Unable to ambulate > 18 months old	☐ Alert
☐ Tube feeding	☐ Continent	☐ Pulse Ox	☐ Wheel chair	☐ Developmental Delay
☐ N/G-tube/G-tube	☐ Other ____________	☐ Vital signs > 2/days	☐ Normal	☐ Mental Retardation
☐ Slow Feeder		☐ Therapy		☐ Behavioral Problems (please describe, if checked)
☐ FTT or Premature		☐ Oxygen		☐ Suicidal
☐ Hyperal		☐ Home Vent		☐ Hostile
☐ IV Use		☐ Trach		
☐ Medications/GT		☐ Nebulizer Tx		
☐ Meds		☐ Suctioning		
		☐ Chest - Physical Tx		
		☐ Room Air		

34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits	38. Neurological Status
☐ Burn Care	☐ Dialysis in home	☐ Level 1 (5 or > surgeries)	Day care Services	☐ Deaf
☐ Sterile Dressings	☐ Ostomy	☐ Level II (< 5 surgeries)	☐ High Tech - 4 or more times per week	☐ Blind
☐ Decubiti	☐ Incontinent – Age > 3 years	☐ None	☐ Low Tech – 3 or less times per week or MD visits > 4 per month	☐ Seizures
☐ Bedridden	☐ Catheterization		☐ None	☐ Neurological Deficits
☐ Eczema-severe	☐ Continent			☐ Paralysis
☐ Normal				☐ Normal

39. Other Therapy Visits ☐ Five days per week ☐ Less than 5 days per week

40. Remarks

41. Pre-Admission Certification Number: ______________________________ 42. Date Signed ____/____/____

43. Print Name of MD or RN: ______________________________

Signature of MD or RN: ______________________________

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date: __________ Admission Date: __________ Approved for ________ Days or ________ Months

45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution?

☐ Yes ☐ No

46A. State Authority MH & MR Screening

Level I/II

Restricted Auth. Code Date

46B. This is not a re-admission for OBRA purposes

Restricted Auth. Code Date

47. Hospitalization Precertification ☐ Met ☐ Not Met

48. Level of Care Recommended by Contractor ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor)	51. Date	52. Attachments (Contractor)
	______________________	____/____/____	☐ Yes ☐ No

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)

This section provides detailed instructions for completion of the ***Form DMA-6 (A)***. Before payment can be made, a ***Form DMA-6 (A)*** must be completed by the ***Primary Care Physician (PCP) and the parent or legal representative*** and signed by the PCP. The Form DMA-6 (A) is considered valid only if it is signed by the ***Primary Care Physician*** and dated.

Section A - Identifying Information

It is the responsibility of the responsible party to see that Section A of the form is completed with the applicant's name and address.

Item 1: **Applicant's Name and Address**
Enter the complete name and address of the applicant including the city and zip code.

The KB Medicaid Specialist will complete the mailing address and county of the originating application.

Item 2: **Medicaid Number**
Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by the KB Team staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

The entire number must be placed on the form correctly. In exceptional instances, it may be necessary to contact the KB Medicaid Specialist for the Medicaid number.

Item 3: **Social Security Number**
Enter the applicant's nine-digit Social Security number.

Item 4&4A: Sex, Age and Date of birth
Enter the applicant's sex, age, and date of birth.

Item 5: **Primary Care Physician**
Enter the entire name of the Primary Care Physician (PCP).

Item 6: **Telephone Number**
Enter the telephone number including area code of the applicant's parent or the legal representative.

Item 7: **Does the parent or legal representative think the applicant should be institutionalized?**
Please check the appropriate box.

Item 8: **Does the child attend school?**
Please check the appropriate box if the member attends school.

Item 9: **Date of Medicaid Application**
Enter the date the family made application for Medicaid services.

Fields below Item 9:
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, please indicate the name of the caregiver.

Read the statement below the name(s) of the caregiver(s) and then;

Item 10: **Signature**
The parent or legal representative for the applicant should sign the DMA-6 (A).

Item 11: **Date**
Please include the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation

Item 12: **History (attach additional sheet(s) if needed)**
Describe the applicant's medical history (Hospital records may be attached).

Item 13: **Diagnosis (Add attachment(s) for additional diagnoses)**
Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

Item 14: **Medications (Add attachment(s) for additional medication(s)**
The name of all medications the applicant is to receive should be listed. Name of drugs with dosages, routes, and frequencies of administration are to be included.

Item 15: Diagnostic and Treatment Procedures
Any diagnostic or treatment procedures and frequencies should be indicated.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative/habilitation, and other health care services the applicant has received or currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization
List any dates the applicant may be hospitalized in the near future for services.

Item 18: Level of Care Recommended
Recommendation regarding the level of care considered necessary. Enter a check in the correct box for hospital, nursing facility, or an intermediate care facility for the mentally retarded.

Item 19: Type of Recommendation
Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

Item: 20: Patient Transferred from (Check one)
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Enter a check in the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could or could not be managed by provision of the Community Care or Home Health Care Services Programs. Enter a check in the box corresponding to "could" and either/both the box (es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.

Item 24: **Physician's Name and Address**
Print the admitting or attending physician's name and address in the spaces provided.

Item 25: **Certification Statement of the Physician and Signature**
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable.

Item 26: **Date signed by the physician**
Enter the date the physician signs the form.

Item 27: **Physician's Licensure Number**
Enter the Georgia license number for the attending or admitting physician.

Item 28: **Physician's Telephone Number**
Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed (Check Appropriate box only)

Licensed personnel involved in the care of the applicant should complete Section C of this form.

Item 29: **Nutrition**
Check the appropriate box (es) regarding the nutritional needs of the applicant.

Item 30: **Bowel**
Check the appropriate box(es) to indicate the bowel and bladder habits of the applicant.

Item 31: **Cardiopulmonary Status**
Check the appropriate box (es) to indicate the cardiopulmonary status of the applicant.

Item 32: **Mobility**
Check the appropriate box (es) to indicate the mobility of the applicant.

Item 33: **Behavioral Status**
Check all appropriate boxes (es) to indicate the applicant's mental and behavioral status.

Item 34: **Integument System**
Check the appropriate box (es) to indicate the integument system of the applicant.

Item 35: **Urogenital**
Check the appropriate box (es) for the urogenital functioning of the applicant.

Item 36: **Surgery**
Check the appropriate box regarding the number of surgeries the applicant has had to your knowledge or obtain this information from the parent or other legal representative.

Item 37: **Therapy/Visits**
Check the appropriate box to indicate the amount of therapy visits the applicant receives.

Item 38: **Neurological Status**
Check the appropriate box(es) regarding the neurological status of the applicant.

Item 39: **Other Therapy Visits**
If applicable, indicate the number of treatment or therapy sessions per week the applicant receives or needs.

Item 40: **Remarks**
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form or any additional comments.

Item 41: **Pre-admission Certification Number**
Indicate the pre-admission certification number (if applicable).

Item 42: **Date Signed**
Enter the date this section of the form is completed.

Item 43: **Print Name of MD or RN**
The individual completing Section C should print their name and sign the DMA-6 (A).

Do Not Write Below This Line
Items 44 through 52 are completed by Contractor staff only.

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name:______________________ DOB: ______ SS#_____________
Diagnosis: ____
____

Recommended level of Care:
☐ Nursing facility level of care ☐ Hospital level of care
☐ Level of care required in an Intermediate Care Facility for MR (ICF-MR)

Medical History: (May attach hospital discharge summary or provide narrative):
____
____
____

Current Needs

	None	Description of Skilled Nursing Needs
Cardiovascular:	____	____________________________________
Neurological:	____	____________________________________
Respiratory:	____	____________________________________
Nutrition:	____	____________________________________
Integumentary:	____	____________________________________
Urogenital:	____	____________________________________
Bowel:	____	____________________________________
Endocrine :	____	____________________________________
Immune:	____	____________________________________
Skeletal:	____	____________________________________
Other:	____	____________________________________

Therapy: Speech sessions/wk ____ PT sessions/wk ____ OT sessions/wk ____ *(attach current notes)*

Hospitalizations within last 12 months: (Attach most recent hospital discharge summary)
Date: _________ Reason: _________ Duration: ______________________
Comments: ____
____

Child in school: _____ Hrs per day _____ Days per wk ___ N/A ____ IEP/IFSP __ *(attach if in effect)*
Nurse in attendance during school day: _____ N/A ____*(attach last month's nursing notes)*

Skilled Nursing hours received: Hrs./day ______ N/A _______
I attest that the above information is accurate and this member meets Pediatric Level of Care Criteria and requires the skilled care that is ordinarily provided in a nursing facility, hospital or facililty whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.

Physician's Signature: ______________________ Date: __________
Primary Caregiver Signature: ______________________ Date: __________

**** Foster Care Applicants must have the signature of the DFCS representative.**

DMA 706
Rev. 08/11

TEFRA/KATIE BECKETT MEDICAL NECCESSITY/LEVEL OF CARE STATEMENT INSTRUCTIONS FOR COMPLETION

This document provides detailed instructions for completion of the TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member (Applicant) Information

1. Enter the Member's Name, DOB and SS#

Diagnosis

1. Enter the Member's primary, secondary, and any third diagnoses relevant to the member's condition

Level of Care

1. Enter a check in the correct box for the recommended level of care.

Medical History

1. Provide narrative of member's medical history or attach documents i.e., hospital discharge summary, etc.

Current Needs

1. Check member's current needs and provide description of skilled nursing needs.

Therapy

1. Include frequency per week of therapies and attach current notes.

Hospitalizations

1. Attach most recent hospital discharge summary and document date, reason and duration.

School

1. Enter a check for member's appropriate school attendance and IFSP or IEP plan.

Signature

1. The primary care physician or physician of record must sign and date.
2. The caregiver (parent or guardian) must sign and date. Foster Care members must have the signature of the DFCS representative.

TEFRA/Katie Beckett

Cost-Effectiveness Form

(Child's physician must complete Form)

The following information is requested for the purpose of determining your patient's eligibility for Medicaid:

Patient's Name:______________________________ Medicaid #:______________________________

Diagnosis:____

Prognosis:____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking for Medicaid to cover for in-home care:

- Physician's services $______________
- Durable medical equipment ______________
- Drugs ______________
- Therapy(s) ______________
- Skilled Nursing Services ______________
- Other(s)________________ ______________

TOTAL $______________

Will home care be as good or better than institutional care?

__________ Yes __________ No

COMMENTS:

____

____

____

____

PHYSICIAN'S SIGNATURE ____

DATE: ____

DMA Form 704
Rev. 10-04

Instructions for Completing the Katie Beckett Cost-Effectiveness Form

This form should be completed by the Katie Beckett child's primary care physician. Instruct the physician to complete the form as follows:

1. Patient's Name – Enter the name of the Katie Beckett child.
2. The MES may provide the Medicaid number, if not known.
3. The physician should enter the diagnosis name, not the ICD code, and the prognosis in the spaces provided. S/he may attach additional information, if needed.
4. The physician should provide the estimated monthly cost of any of the medical services which the Katie Beckett child regularly receives. If the physician will not complete everything applicable, it is permissible to have other medical service amounts entered by the providing agency/pharmacy/therapist. Have that entity initial next to the dollar amount. At the very least, the physician must complete the cost of his/her services.
5. The physician must indicate if home care will be as good as institutional care.
6. It is not necessary to enter any comments. However, it will be helpful to the MES if you will indicate for each medical service the percentage amount that is covered by any private/group insurance plan.
7. The form must have an original signature of the primary care physician. Stamped signatures are not acceptable. The date should be the date of the signature.

CITIZENSHIP/IDENTITY VERIFICATION CHECKLIST

AU NAME: ______________________

AU NUMBER: ______________________

CITIZENSHIP/IDENTITY MUST BE VERIFIED FOR ALL MEDICAID APPLICATIONS/REVIEWS

If you have already provided acceptable verification of your citizenship/identity as listed below, or are a recipient of SSI or Medicare further verification is not necessary. Please check with your Medicaid case manager for clarification. Please provide one of the following, and return to your county DFCS case manager.

No Identity Required on these Citizenship Verifications:

- US Passport (not limited passports)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of Citizenship (N-560 or N-561)

Identity Required with these Citizenship Verifications:

- US Public Birth Record showing birth in one of the 50 states; District of Columbia; American Territories; or Guam
- US birth certificate or data match with a State Vital Statistic Agency
- Certification of Report of Birth (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the U.S.(FS-240)
- Certification of Birth Abroad (FS-545)
- United States Citizen Identification Card (I-197 or the prior version I-179)
- American Indian Card (I-872) with the classification □KIC□(Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
- Collective Naturalization document/Northern Mariana Identification Card (I-873)
- Final Adoption Decree
- Evidence of civil service employment by the US government
- Official Military record
- Federal or State census record showing US citizenship indicating a US place of birth
- Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs
- Statement signed by the physician or midwife who was in attendance at the time of birth
- One of the following documents created at least 5 years before the application for Medicaid showing a US place of birth :
  - Extract of hospital record on hospital letterhead established at the time of person□s birth
  - Life, health or other insurance record
  - An amended US public birth record
  - Medical clinic(not Health Dept.), doctor or hospital record indicating a US place of birth
  - Institutional admission papers from nursing home, skilled nursing care facility or other institution

If you do not have any of the above, please contact your case manager to complete an affidavit of citizenship or identity.

Acceptable Verification of Identity:

- State Driver□s license bearing the individual□s picture **or** Georgia Identification Card
- Certificate of Indian Blood; US American/Alaska Native tribal document; or Native American Tribal Document
- US Military Card or draft record; Military dependent□s ID card with photograph; US Coast Guard Merchant Mariner Card
- Identification card issued by federal, state or local government agencies or entities with photo or identifying information
- School Identification card with a photograph
- US passport issued with Limitations
- Data matches or documents from law enforcement or corrections agencies such as police or sheriff□s departments, parole office, DJJ and Youth Detention Centers

For individuals under age 16 who are unable to produce a document listed above, the following documents are acceptable to establish identity only:

- School record including report card, daycare or nursery school record. (Must verify record with issuing school)
- Clinic, doctor or hospital record showing date of birth. An immunization record is acceptable if it is part of a medical record certified by the medical provider.
- Affidavit signed under penalty of perjury by a parent/guardian. **(Contact your case manager at the county DFCS.)**
- A signed Declaration of Citizenship form that includes the date and place of birth of the child. **(Contact your case manager at the county DFCS.)**

All documents that verify citizenship must be either ORIGINALS or copies CERTIFIED by issuing

agency. If you have questions, please contact your local county Medicaid case manager.

INSTRUCTIONS FOR COMPLETING
GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE
FORM DMA-285

1. LEGIBLY PRINT information in every applicable field on the form.
2. If the DMA-285 is for a legal action, Trust or QIT, write "Legal Action", "TRUST" or "QIT" in red ink at the top of the form.
3. If this form is completed to report a change, personal reimbursement, death or cancellation of an insurance policy, write "Change", "Cancellation", "Death", "Reimbursement", etc. in red ink at the top of the form. You may use a copy of the original 285 sent to DMA if it is legible.
   - If you have a letter confirming cancellation of the policy, attach the letter to the 285.
   - If the A/R has never had the insurance or if it was cancelled several years ago, attach to a 285 a copy of the MHN screen showing the insurance and annotate that the A/R has never had or has not had the insurance in years.
   - If you are reporting the death of an A/R who has a QIT, also write the date of death next to "Death" as MM/DD/YY.
   - If the A/R has personally been reimbursed for a service covered by Medicaid or has received a settlement from a pending legal action, mail/fax a copy of the existing 285 and attach a copy of the Explanation of Benefits (EOB) or letter outlining the settlement that accompanies the check. Attach a copy of the check, if available.
4. Do not submit this form if the only health insurance the A/R(s) have is Medicare or Medicaid.
5. Complete the name and address, etc. of the head of household in the AU as entered in SUCCESS.
6. Check whether the case is for an application or redetermination.
7. If you plan to send this form to DMA for an active policy, trust, etc., check "Yes" to having a private, group or government health insurance…..
8. Check yes or no as appropriate if someone else has health insurance on the A/R(s).
9. Check the appropriate type of policy that exists for the A/R(s). Attach a copy of the front and back of the health insurance card, if possible.
10. If the form is for a trust or QIT, cross out "Policy Holder" and write in "Trustee". Enter the name of the policy holder or trustee.
11. Enter the address of the policy holder or trustee as appropriate.
12. Enter the policy holder's SSN.
13. Enter the phone number of the policy holder or trustee.
14. Enter the name address, policy number and effective date in the appropriate fields. If insurance is cancelled, write "Cancelled" above "Effective Date" and the date cancelled in the space available.
15. If the insurance policy is through an employer, enter the information pertaining to the employment in the spaces provided.

16. List the names of the household members who are Medicaid A/Rs covered under the insurance policy. Enter their relationship to the A/R given as the "Case Name" at the top of the form. If it's the same write "Self". Provide the date of birth. Enter the SUCCESS ID #. Enter the SSN of the individual.
17. If possible, have the A/R or PR sign the document in the two spaces provided.
18. The worker should LEGIBLY PRINT his/her name, DIRECT phone number and DFCS county.
19. See Section 2230 for mailing/faxing instructions.

NOTE: PCG, the entity charged with handling DMA-285, has a 30 day standard of promptness. If it is necessary to have an immediate correction made concerning a TPR, fax the information to PCG rather than mailing. At times MHN may show insurance coverage that the MES is not aware of. Always double check with the A/R before assuming that the insurance shown is not valid. However, a pharmacy should never deny a member their prescriptions because of TPR issues. They have override codes to enter to make the prescription claim be accepted.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH - THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE

CASE NAME: ______________________ CASE NO: ______________________

ADDRESS: ______________________ SSN: ______________________

______________________ PHONE NO: ______________________

TYPE OF CASE: (Check all that apply) ☐ INITIAL APPLICATION ☐ HIPP REFERRAL ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION

EFFECTIVE DATE OF CHANGE OR CANCELLATION:____/____/____

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25): 42 CFR 433. 135-139). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

Do you have a private, group, or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) ☐ YES ☐ NO

Does your spouse, parent or stepparent have any private, group, or government health insurance that pays any of the cost of your medical care? ☐ YES ☐ NO

Is policyholder an Absent Parent? ☐ YES ☐ NO

Names of Covered Individuals in Household (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	

Are any of these persons pregnant? ☐ YES ☐ NO If yes, Name ______________________ Date of Delivery ______

ATTACH A COPY OF INSURANCE CARD/POLICY AND A COPY OF SNT

Do any of the persons listed above have a chronic medical condition? ☐ YES ☐ NO If yes, Name ______________________ Condition ______________________

______________________ (Insurance Company Name) (____) ______ (Telephone Number)

______________________ (Address) (City) (State) (Zip)

______________________ (Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

______________________ (Policy Effective Date) (Policy Termination Date)

______________________ (Employer Name) (Telephone Number)

______________________ (Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)

- 01 - HOSPITAL INPT.
- 07 - DRUG/STND
- 08 - MAJOR MED.
- 09 - DENTAL
- 10 - VISION
- 15 - LTC/NH
- 16 - HMO/DRUG
- 17 - MED. SUPP A
- 18 - MED. SUPP B
- 22 - HMO/STND
- OTHER______________________

I authorize the release of information necessary to identify health/liability insurance benefits to the Department of Community Health. I also certify that the above information is correct.

Signed ______________________ Date ______________
Member or Authorized Person

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.

Signed ______________________ Date ______________
Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY______________

INSTRUCTIONS FOR COMPLETING
GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE
FORM DMA-285

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