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.

PERSONAL INFORMATION: You may have someone help you complete this application.

Applicant's Name (Last, First, Middle Initial)	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial) Elder Law Practice of David L. McGuffey
Mailing Address	
Street Address	Mailing Address P.O. Box 2023
City State Zip Do you own/are you purchasing home? ☐ Y ☐ N	City State Zip Dalton Georgia 30722-2023
Phone 706-428-0888 County E-Mail Address info@mcguffey.net	Phone: 706-428-0888 E-Mail Address: info@mcguffey.net
Nursing Facility (if applicable)	Relationship to Individual: Attorney

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**

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 D** (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 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, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

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 receives. 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, handicap, religion, national origin, or political belief. 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, are an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other mental institution that have their medical care paid by Medicaid will be subject to the Medicaid Estate Recovery Program. Additionally, Medicaid members who are 55 years of age or older and who receive home and community based services or are enrolled in and receive services through a waiver program are also subject to Estate Recovery. 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:**

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the United States Department of Homeland Security (DHS) 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	Lawfully Admitted Immigrant (check whichever applies)	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID# (If applicable)
					A-
					A-
					A-
					A-
					A-

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

_____ _____
SIGNATURE (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth (city, State, Country)	U.S. Citizen	Lawfully Admitted Immigrant (check whichever applies)	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID# (If applicable)
					A-
					A-

I, _____ attest to the best of my knowledge to the identity of the adult(s) listed
(PRINT NAME)
above and certify under penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (DATE)

Georgia Department of Human Services

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

☐ ninety (90) days unless I specify an earlier expiration date here:

(Date)

☐ one (1) year.

☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or relationship to Individual)

(Signature of Parent or other legally Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

Member Name _____ SS No._____

Official Notice of the Georgia Medicaid Estate Recovery Program

The Georgia Department of Community Health (DCH) has a new program called Medicaid Estate Recovery. Federal law requires all states to recover Medicaid monies paid for your medical care from your estate. Your estate will include your home and any other assets. This notice will inform you of how you may be affected by Medicaid Estate Recovery.

Medicaid members who, at any age, are an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution that have their medical care paid by Medicaid will be subject to the Medicaid Estate Recovery Program. Additionally, Medicaid members who are 55 years of age or older and who receive home and community based services or are enrolled in and receive services through a waiver program are also subject to Estate Recovery.

After your death, your executor, personal representative or heirs will be notified before any recovery is attempted from your estate. Upon notification, the heirs of your estate will be given an opportunity to show that they meet one of the exceptions in the law that will delay recovery and they will be told how to request an undue hardship waiver. Recovery will be delayed until the death of the member's surviving spouse, until the member's surviving child or children reaches twenty-one (21) years of age or until the death of an adult child or children who are blind or permanently disabled. Recovery will also be delayed until the following persons are not legally and continuously residing in the Member's home: a sibling of the member who was residing in the member's home for at least one year immediately before the date that the member was institutionalized and a child of the member who was residing in the member's home for at least two years before the date that the member was institutionalized and who has established to the satisfaction of the Department that he or she provided care that permitted the individual to reside at the home rather than to become institutionalized.

If Medicaid has paid for your at home or institutionalized services, the state can place a lien on your home. No lien will be placed on a member's home if the following persons are living in the home: the member's spouse, the member's child or children under twenty-one years of age, a member's disabled child of any age; or a member's sibling with an equity interest in the home who has lived in the home for at least one year before the member received at home or institutionalized services.

Upon notification of the State's intent to file a lien on your home, you will be given an opportunity to show that you meet one of the exceptions in the law that will delay the placement of a lien. The member shall have the right to an administrative hearing to prove that the member is not permanently institutionalized. Also, it is important to note that if you transfer real or personal property without adequate consideration, meaning for less than fair market value, a penalty may be applied and your eligibility could be affected.

An informational brochure is being developed and will be available soon at your local county Department of Family and Children Services (DFCS) office or directly from the Estate Recovery Office in Atlanta. If you have any questions, please call the Estate Recovery office at 770-916-0328.

I have received a copy of the Official Notice of the Georgia Estate Recovery Program.

_____ _____

Member's Signature Date

_____ _____

Authorized Representative/Witness/Responsible Person Date

_____ _____

Case Manager Date

DMA-315 (11/10)

ABD Medicaid Burial Exclusion & Designation Form

(A/R or Spouse) _____ Date _____

SECTION ONE **BURIAL CONTRACT(S):**		
Name of Funeral Home:		
Date contract was purchased:		
Is contract paid in full?	Yes, list purchase price minus any included sales tax: No, list what has been paid to date:	(A)

Determine the value of any PAID IN FULL burial space items. List below:

Burial Space Item	$Value
Total (B)	

Subtract total paid in full burial space items from purchase price or amount paid to date

As of:	A -	B =	Value of burial contract (C)
			(C)

SECTION TWO **BURIAL FUND(S):**	
Value of any Burial Fund:	
Designated Value:	
TOTAL	

SECTION THREE **LIFE INSURANCE:**			
Face Value and Cash Surrender Value of each policy for **Non FBR and FBR (circle the type):**			
Face Value **Non FBR**	CSV **Non FBR**	Face Value **FBR**	CSV **FBR**
Total	Total	Total	Total

ABD Medicaid Burial Exclusion & Designation Form

SECTION FOUR TOTAL BURIAL ASSETS	
Total of Burial Contracts (C from Section 1)	$
Total of Burial Funds (Designated value)	$
Total Face Value of Life Insurance for Non FBR	$
Total Value of Life Insurance for FBR	$
Total Burial Assets	$

SECTION FIVE
EXCLUDED BURIAL ASSETS

The following assets are being applied toward the burial exclusion allowance of ($10,000/$1500):

Type	Company/Bank Name	Account/Policy #	Amount applied to exclusion:
Burial Contracts			
Burial Funds			
Life Insurance			
Total burial assets applied to exclusion:			

SECTION SIX
COUNTABLE BURIAL ASSETS

The following assets cannot be excluded and are being applied to the resource limit:

	Company/Bank Name	Account/Policy #	Amount counted toward resource limit:
Burial Contracts			
Burial Funds			
Life Insurance			
Total burial assets counted toward resource limit:			

I understand that any designated burial assets that are used for other purposes will be treated as income to me in the month following the month it is determined that the designated assets were used for a purpose other than burial. I further understand that any designated burial assets that are not used for my burial may be subject to estate recovery.

_____ _____

Client or Personal Representative Date

****

NOTE: If burial funds or burial contract (non-excluded items) are excluded, the client or personal representative must sign this form. Otherwise, the form must be completed and placed in the case record as documentation, but does not have to be signed.

Nathan Deal, Governor

Keith Horton, Commissioner

Georgia Department of Human Services ▪ Office of the General Counsel ▪ Suite 29.250
▪ Two Peachtree Street, NW ▪ Atlanta, Georgia 30303-3142 ▪ 404-657-9761 ▪ 404-657-1123 (Fax)

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Effective Date: August 15, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact:
Georgia Department of Human Services
HIPAA Privacy Officer
HIPAA1@dhr.state.ga.us
(404) 656-4421 phone
(404) 657-1123 fax

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this Notice.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways DHS may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, DHS will use and disclose Health Information only with your written permission. You may revoke such permission at any

time by writing to the HIPAA Privacy Officer at the contact information above.

For Treatment. DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

For Health Care Operations. DHS may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that quality care is received and to operate, manage, and administer the functions of the agency. For example, DHS may use and disclose information to make sure the medical care you receive is of the highest quality. DHS also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. DHS may use and disclose Health Information to contact you to remind you of an appointment with a physician. DHS also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, DHS may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. DHS will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. DHS may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such

functions or services. For example, DHS may utilize the services of a separate entity to perform billing services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, DHS may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, DHS may release Health Information as required by military command authorities. DHS also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. DHS may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. DHS may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if it is believed a patient has been the victim of abuse, neglect or domestic violence. DHS will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. DHS may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. DHS may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, DHS may disclose Health Information in response to a court or administrative order. DHS also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. DHS may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. DHS may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. DHS also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. DHS may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. DHS may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE DHS TO PROVIDE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

Disaster Relief. DHS may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. DHS will provide you with an opportunity to agree or object to such a disclosure whenever it is practical to do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to DHS will be made only with your written authorization. If you do provide DHS an authorization, you may revoke it at any time by submitting a written revocation to the above-referenced Privacy Officer. Upon receipt, DHS will no longer disclose Protected Health

Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information DHS has about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the above referenced HIPAA Privacy Officer. DHS has up to 30 days to make your Protected Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information DHS has is incorrect or incomplete, you may request DHS to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures DHS made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your

spouse. To request a restriction, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid "out-of-pocket" in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the above-referenced HIPAA Privacy Officer.

CHANGES TO THIS NOTICE:

DHS reserves the right to change this notice and make the new notice apply to Health Information already obtained as well as any information received in the future. DHS will post a copy of the current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint, in writing, by contacting the above-referenced HIPAA Privacy Officer. **You will not be penalized for filing a complaint.**

You may also file with the Secretary of the Department of Health and Human Services. For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

I have read, understand, and acknowledge receipt of the DHS HIPAA Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name

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

CASE NAME:_____ CASE NO:_____

ADDRESS:_____ SSN:_____

_____ PHONE NO:_____

TYPE OF CASE: ☐ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
(Check all that apply) ☐ HIPP REFERRAL 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.	15 – LTC/NH
07 – DRUG/STND	16 – HMO/DRUG
08 – MAJOR MED.	17 – MED. SUPP A
09 – DENTAL	18 – MED. SUPP B
10 – VISION	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_____

Case Worker Name:_____ Phone No:_____ County_____

DMA-285-REV. (01/06)

Georgia Department of Human Services

_____ County

Division of Family and Children Services

NOTIFICATION REQUIREMENT: TRANSFER OF ASSETS TO SPOUSE

(Spousal Impoverishment)

_____

_____ _____

Date

_____

_____

_____

_____ _____

Recipient Name Medicaid Number

_____

Name of Spouse

The above named individual has been determined eligible for Medicaid Benefits. As part of the eligibility determination process, the individual has agreed to transfer ownership of his/her resources to his/her spouse. In order for the individual to remain eligible for Medicaid, the resources named below must be transferred to the spouse no later than _____(the annual review date). Your Medicaid Eligibility Specialist must be given verification of the transfer no later than the annual review date. If the resources are not transferred by _____(the annual review date), the individual will become ineligible for Medicaid effective _____(month).

Below is a list of the resources which must be transferred, and their values:

RESOURCE	VALUE

I agree that the assets listed above are to be transferred to my spouse. **YES** **NO** (circle one)
I DO **DO NOT** (circle one) want to make my income available to my spouse.
I want to give: ☐ the maximum amount possible or ☐ $_____ per month to my spouse.

The above action will be effective _____. _____

Applicant's/Authorized Representative's Signature

_____ _____

Signature of Medicaid Eligibility Specialist Telephone Number

INSURANCE CLEARANCE

_____ County Department of Family and Children Services

_____

_____

_____ Date

_____

_____

_____

RE: _____ _____
Name of Applicant/Recipient AU #

_____
Mailing Address

The above named individual has applied to this agency for assistance and has given us permission, as evidenced by the signed authorization for insurance clearance set forth here under, to make the necessary financial investigation.

Therefore, we shall appreciate your completing the section below on policy number _____ and returning the completed form to us at the earliest date possible.

_____
Signature of Medicaid Eligibility Specialist

AUTHORIZATION FOR INSURANCE CLEARANCE

To Whom It May Concern: Date: _____

I, the undersigned hereby authorize representatives of _____ County Department of Family and Children Services to be given any information that they may desire concerning my insurance.

Signed: _____ Signed: _____
Signature of Witness Signature of Applicant/Recipient

Address: _____ Address: _____

INFORMATION REQUESTED ON ABOVE-DESIGNATED POLICY

Owner of Policy: _____

Current face value of policy: _____

Date policy was issued: _____

Date and amount of any outstanding loan: _____

Present cash surrender value: _____

Amount of accrued dividends: _____ How often are dividends paid? _____

Can policyholder elect to receive dividends? ☐ Yes ☐ No

_____ _____
Date Signature/Title

Prepare in duplicate: Mail original addressee. File duplicate in case folder.

Form 106 (R. 04/04)

Georgia Department of Human Services
Division of Family and Children Services

Designation of Cemetery Lots

AU Name: _____ AU Number: _____

I own a cemetery lot at _____

located in _____, which consists of _____ (number) of gravesites.

_____ Vacant Spaces	(Documented by one of the following):
_____ Occupied Spaces	Deed to the lot _____
	Cemetery letter _____
	Other (Specify) _____

The following person(s) are buried there:

Person's Name	Relationship to Client
_____	_____
_____	_____
_____	_____
_____	_____

The remaining spaces are intended for:

Person's Name	Relationship to Client
_____	_____
_____	_____
_____	_____
_____	_____

_____
Client Signature

_____
Date

Note: A burial space owned by a deemor may be excluded only if it is intended for the use of the eligible individual, the eligible individual's spouse, or another member of the eligible individual's immediate family.

Immediate Family – includes the eligible individual's spouse, minor and adult children, step-children, and adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those persons. Dependency and living in the same household are not factors. Immediate family does not include the members of an ineligible spouse's family unless they are also within the appropriate degree of relationship to the eligible individual as defined above.