DCH/Katie Beckett Application Information

Please return this application directly to the address below:

DCH/Katie Beckett Unit

2211 Beaver Ruin Rd. Suite 150 Norcross, GA. 30071

If you have any questions, please contact our office at:

(678) 248-7449 – Phone

(678) 248-7459 - Fax

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

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept.

Check block(s) that apply to you:

- ❑ Pregnant Woman
- ❑ Women's Health
- ❑ Child under 19
- ❑ Parent Caretaker
- ❑ Katie Beckett
- ❑ Chafee Independence Program Medicaid
- ❑ Planning for Health Babies (P4HB)

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 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).**

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:	
Electronic Communication: Yes___ or No___ (optional)*	What is your Preferred Language? If an interview is required, will you need an interpreter? Yes__ No__		

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?

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE

You can give a trusted person or organization permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.

This person or organization is called an "authorized representative." If you ever need to change your authorized representative, contact Division of Family and Children Services (DFCS) at (877) 423-4746. If you are a legally appointed representative for someone on this application, submit proof with the application.

Person Name: (Please Print) FIRST Last		Organization Name (if applicable):	
Address:	City:	State:	Zip Code:
What is your Preferred Language? If an interview is required, will you need an interpreter? Yes ___ No ___	Phone Number(s):	Electronic Communication: Yes___ or No___ (optional)* E-mail address:	

Authorized Representative Duties: Sign application on applicant's behalf ❑ Complete and submit renewal form ❑ Receive copies of notices and other communication ❑
Act on behalf of applicant in all other matters ❑

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance <u>for Authorized Representatives</u> (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?

*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.

Please list all persons living with you for whom you want or DON'T want Medicaid, including yourself. You do not have to provide an 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).

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Does this person need health coverage? (Y/N)	Social Security Number	Is this person a U.S. Citizen, U.S. National or qualified alien/immigrant? (Y/N)	Does the Father of this child live in your home? (Y/N)	Does the Mother of this child live in your home? (Y/N)

If you or other household members are a Naturalized Citizen, or a qualified alien/immigrant complete the following chart.

Name First	Middle Initial	Last	Immigration document type	Alien/Certificate number	Have you lived in the U.S. since 1996? (Y/N)	Are you, your spouse or parent a veteran or an active-duty member of the U.S. military? (Y/N)

Are you pregnant? ❑Yes ☐ No; If yes what is the estimated due date? _____; and how many babies are expected? ____; If no, did you deliver or was a pregnancy terminated the last 12 months? ❑Yes ☐ No; If yes, what was the delivery/termination date? _____; and how many babies were delivered/expected? ____; Are you able to have a baby? ❑Yes ☐ No; Have you ever delivered a baby weighing less than 2500 grams (5 pounds, 8 ounces)? ❑Yes ☐ No; Have you delivered a baby weighing less than 1500 grams (3 pounds, 5 ounces) on or after January 1, 2011? ❑Yes ☐ No; Do you have any unpaid medical bills from the past three months? ❑Yes ☐ No; If yes, which months? _____; Are you currently covered by other Health Insurance? ❑Yes ❑No; Are you currently on Medicaid? ❑Yes ☐ No; If yes, list Insurance Company and policy number: _____; Does anyone in the household have any private health insurance? ❑Yes ☐ No
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/SELF-EMPLOYMENT, TAX FILER INFORMATION, DEDUCTIONS 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.

Income	Gross Amount per Paycheck (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:			

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ❑Yes ❑No
   If **YES**, who? (List each person who plans to file)
   _____
2. Will any of the tax filers listed file jointly with a spouse? ❑Yes ❑No
   If **YES**, please list spouse's name: _____
   _____
3. Will any of the filers claim any dependents on their tax return? ❑Yes ❑No
   If **YES**, please list the names of the dependents: _____
   _____
4. Will anyone be claimed as a tax dependent on someone else's return? ❑Yes ❑No
   If **YES**, please list the name of the tax filer and the tax dependents:
   _____
   _____

   How is the tax dependent related to the tax filer?
   _____

If you or anyone on page 1 on this application is self-employed, complete the chart below.

Type of self-employment	Name of person self-employed	Monthly gross amount	Monthly business expenses amount

DEDUCTIONS: Check all that apply, give the amount and how often you pay it.

❑ Alimony paid Amount: _____ How often? _____ ❑ Student loan interest Amount: _____ How often? _____

❑ Health Insurance Premiums, 401K, and Other Pre-Tax Deductions $_____ How often? _____

❑ Other deductions Type: _____ Amount: _____ How often? _____

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?	If Yes to Medical Coverage, please list name of insurance company & group number

EXPRESS LANE ELIGIBILITY:

Express Lane Eligibility (ELE) is an automatic process to enroll or renew eligible children under the age of 19 who are receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) into the Medical Assistance program.
If you are receiving SNAP or TANF, the Division of Family and Children Services (DFCS) will use the household size, residency, and income information from SNAP or TANF, but DFCS will verify citizenship or immigration status using Medical Assistance rules to make an ELE determination to enroll or renew the children in Medicaid or PeachCare for Kids®. If your children are eligible for PeachCare for Kids®, they may be subject to a premium. DFCS will send you a determination notice, let you make any changes and allow you to opt out at any time.

If you would like your children to be evaluated for Medical Assistance using the ELE process, please select yes or no below.
☐Yes ☐No

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.

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agree that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law and/or regulations.

- ❑ I declare under penalty of perjury that I am a U.S. Citizen, U.S. National or qualified alien in the United States. If I am a parent or legal guardian, I declare that the applicant(s) is a U.S. Citizen, U.S. National or qualified alien in the United States.
- ❑ I declare 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), U.S. National(s) or qualified alien in the United States. I further certify under penalty of perjury that all of the information provided on this application is true and correct to the best of my knowledge.

Applicant Signature:_____ Date: _____

Authorized Representative Signature: _____ Date: _____

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 (877) 423-4746 or the DCH Katie Beckett (KB) Team 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 from the KB Team 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, 29th Floor, Atlanta, GA 30303, (877) 423-4746. 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. The DCH email is: dch.adarequests@dch.ga.gov.

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. The email for DCH Civil Rights complaints is: dch.civilrights@dch.ga.gov. The link for the DCH Civil Rights process and complaint form is located at https://dch.georgia.gov/adasection-504-and-civil-rights.

**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 DHS, you may file discrimination complaints by contacting your local DFCS office or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746 (voice).

CITIZENSHIP/IDENTITY VERIFICATION AU NAME: _____

CHECKLIST AU NUMBER:_____

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

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 the DFCS Customer Service line or your local county DFCS office for clarification.

Please provide one of the following, and return using the contact information on the verification checklist.

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 the DFCS Customer Service line or your local county DFCS office 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. The Form 3231 immunization record from the Department of Public Health (DPH) is acceptable if an immunization date on the form was documented before the individual's 16th birthday.
- Affidavit signed under penalty of perjury by a parent/guardian**. (Contact the DFCS Customer Service line or your local county DFCS office.)**
- A signed Declaration of Citizenship form that includes the date and place of birth of the child. **(Contact the DFCS Customer Service line or your local county DFCS.)**
- All documents that verify citizenship/identity must be either ORIGINALS or copies CERTIFIED by issuing agency.

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: ☐ 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

EFFECTVIE DATE OF MEDICAID ELIGIBILITY_____

Case Worker Name:_____ Phone No:_____County_____

DMA-285-REV. (01/06)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP PROGRAM) – DMA 124

Head of Household

Provide the name of the head of household and address and telephone number where he or she may be contacted if additional information or data verification is required.

Referral Source

Provide the name and address of the person completing the application. A copy of the decision on the application will be returned to the referral source.

1. **Complete the following information regarding your health insurance policy.**

If known, complete insurance information is helpful. Enter the complete name of the policy holder, BOTH the insurance group number, if applicable, and policy number, if applicable, address and telephone number of the insurance company. This information is usually available on the member's insurance card.

2. **What is the annual Maximum Out of Pocket Expense?**

If known, enter the maximum out-of-pocket expense per individual and for the entire family. The out-of-pocket expense should not be confused with the lifetime limit of the policy. The lifetime limit is the maximum amount of coverage offered by the policy.

3. **Is the deductible included in the out of pocket expense?**

If the annual deductible amount is included in the out-of-pocket expense, check "Yes". If not, check No".

4. **What is the annual deductible?**

If known, enter amount of the annual deductible. If unknown, leave blank.

5. **Is this policy an HMO or PPO?**

If known, check "Yes" if the policy is an HMO or PPO and "NO" if not. If unknown, leave blank.

6. **Complete the following information regarding the employer offering this policy.**

Provide employers name, address and telephone number**. Please do not provide the employee's direct phone number.** We will need to verify information with the employer and not the employee.

7. **List all Medicaid eligible persons covered under this policy.**

List all persons living at this address who are Medicaid eligible and eligible for coverage under this policy. Enter the full name, Social Security Number, date of birth, Medicaid identification number, relationship to the policy holder and gender for each person. If there are more than five persons, attach a second form.

8. **Are any of these persons pregnant?**

If any person in #7 above is pregnant, check "Yes" and enter the expected delivery date. If none are pregnant, check "No".

9. **Have any of the persons in #7 above been diagnosed with a medically expensive condition?**

If any person in #7above is currently diagnosed with a medically expensive condition, enter the individual's name and the diagnosis. If no medically expensive conditions exist, enter "No". Medical conditions include but are not limited to: Diabetes, Blood Disorder, Cancer, Mental Illness/Retardation, Heart Condition, Asthma, Scoliosis or other Back Injury, Stroke, Seizure Disorder, Kidney/Liver Disorder, Alcohol/Drug Addiction, HIV Positive/AIDS.

10. **How much are the premiums for this policy?**

Enter the amount the policy holder pays for insurance coverage. Check the frequency of premium payments.

11. **Check the services covered under this policy**

Hospital: Medical inclusive of room and board charges
Physician: Professional services offered by physicians
Pharmacy: Drugs and pharmaceuticals
Dental: Oral care - both routine and emergency
Home Health: Care and services provided in the insured person's home
Long Term Care: Care provided in a non acute setting i.e. Nursing Facility

This information is best obtained directly from the insurance carrier. If you do not have access to the carrier and do not know the information, leave blank.

12. **Complete the following information if COBRA benefits might be available**

If the policy holder is eligible for COBRA benefits, check "Yes" if COBRA forms have been received, and "No" if none received. If "Yes", enter date received. Enter the last employment date. Indications of COBRA coverage might be a recent job termination, recent layoff from a job or a new job where the benefits do not cover a pre-existing condition.

13. **Can we contact your employer and/or insurance carrier to verify this information?**

Check "Yes" if the employer and/or insurance company can be contacted for verification. If "No" is checked, the application will be denied for insufficient information to process the application.

14. **Has the applicant or any dependents been involved in an accident?**

Check "Yes" if the applicant or any of the dependents listed were involved or injured in an accident that required medical attention within the last 12 months. If an attorney or insurance company is involved, please obtain this information and note it on the application. If no accidents occurred, please check "NO"

15. **Sign and date this application.**

The applicant does not have to be the policy holder. However, the policyholder must sign and date the application upon completion. Please mail the completed application to the following address:

HIPP Unit
5660 New Northside Drive
Suite 750
Atlanta, GA 30328-5829

Should you have any questions, you may contact the HIPP Unit directly at 770-980-9777.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GAINWELL TECHNOLOGIES/HIPP UNIT – 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084 Tel: (678) 564-1162, Option 1
Fax: (800) 817-1769 Email: hippga@gainwelltechnologies.com

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

Head of Household:		Referral Source:	
Address:		Address:	
City:	State:	City:	State:
Zip:	Telephone #:	Zip:	Telephone #:

1. Complete the following information regarding your health insurance policy.
Policyholder's Name:_____ Insurance Co. Name: _____
Policy Number:_____ Insurance Co. Address:_____
Group Number: _____ City/State/Zip:_____
Policyholder's Social Security Number:_____ Telephone #: _____
Policyholder's Date of Birth: _____ Policyholder's Email:_____

2. Is the policy referenced in #1 the primary policy? YES____ NO_____

3. Is there a secondary policy with another employer? YES____ NO_____
(If yes, please provide the information for the secondary policy on a separate page)

4. Complete the following information regarding the employer offering the policy referenced in #1.
Employer Name: _____ Employer Address:_____
Employer Telephone:_____ City/State/Zip:_____

5. List all Medicaid eligible persons covered under this policy (use back of application for additional space).

NAME:	SSN	BIRTHDATE	MEDICAID ID #	RELATIONSHIP TO POLICYHOLDER	MALE/ FEMALE
1.		/ /			
2.		/ /			
3.		/ /			
4.		/ /			
5.		/ /			

6. Are any of these persons pregnant? Yes_____ NO_____
If yes:
Name Expected Date of Delivery Name Expected Date of Delivery

_____/_____/_____ _____/_____/_____

7. Have any of the persons in #5 been diagnosed with a medical condition? If yes, please list all medical conditions or diagnosis (please provide a separate page if additional space is needed).

Name Condition
YES _____ **NO** _____

8. If known, how much are the premiums for this policy? $_____

9. How often is the premium amount paid?

□ WEEKLY □ BIWEEKLY □ SEMIMONTHLY □ MONTHLY □ QUARTERLY □ OTHER

10. Complete the following information if COBRA benefits may be available from a former employer:
Have you received COBRA forms? **YES ____ NO____** Date COBRA forms received _____/_____/_____
Last Date of Employment _____/_____/_____ **(Please attach copy of COBRA enrollment packet to this application)**

11. Can we contact your employer and/or insurance carrier to verify this information? YES_____ NO_____

12. Was applicant or any dependent injured at work or in an accident in the last 12 months? YES____ NO____ If yes,
Attorney Name, if applicable: **Insurance Company, if applicable:**
_____ _____

13. Please sign and date this application (TO BE SIGNED BY POLICYHOLDER ONLY).

_____ _____
Policyholder's Signature **Date**

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

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

It is important that EVERY item on the DMA-6(A) is answered, even if it is answered as N/A (not applicable). Make sure that the physician or nurse who completes some of the sections is aware of this requirement. The form is only valid for 90 days from the date of the physician's signature. The form should be completed as follows:

Section A – Identifying Information

Section A of the form should be completed by the parent or the legal representative of the Katie Beckett child unless otherwise noted. All reference to "the applicant" means the child for whom Medicaid is being applied for.

Item 1: Applicant's Name/Address
Enter the complete name and address of the applicant including the city and ZIP code. For DFCS County enter the applicant's county of residence.

Item 2: Medicaid Number
To be completed by county staff.

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

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

Item 5: Primary Care Physician
Enter the entire name of the applicant's Primary Care Physician.

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

Item 7: Does guardian think the applicant should be institutionalized?
If the Katie Beckett applicant were not eligible under this category of Medicaid, would s/he be appropriate for placement in a nursing facility or institution for the intellectually disabled. Check the appropriate box.

Item 8: Does the child attend school?
Check the appropriate box.

Item 9: Date of Medicaid Application
To be completed by county staff.

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, include 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) legibly.

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

Section B – Physician's Examination Report and Recommendation
This section must be completed in its entirety by the Katie Beckett child's Primary Care Physician. No item should be left blank unless indicated below.

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. Please note the ICD codes. Depending on the diagnosis, a psychological evaluation may be required. If you have an evaluation conducted within the past three years, include a copy with this packet.
Item 13A: ICD-10 Diagnosis Code (Add attachment(s) for additional diagnoses)
Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines.

Item 14: Medications – Add attachment(s) for additional medications(s))
The name of all medications the applicant is to receive must be listed. Include name of drugs with dosages, routes, and frequencies of administration.

Item 15: Diagnostic and Treatment Procedures
Include all diagnostic or treatment procedures and frequencies.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative and other health care services the applicant has received or is 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 anticipated dates of hospitalization for the applicant. Enter N/A if not applicable.

Item 18: Level of Care Recommended
Check the correct box for the recommended level of care; nursing facility or intermediate care facility for the intellectually disabled. If left blank or N/A is entered, it is assumed that the physician does not deem this applicant appropriate for institutional care.

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 for 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?
Check the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could be managed by provision of the Community Care of Home Health Care Services Programs. Check either/both box(es) corresponding to Community Care and/or Home Health Services if either/or 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 or an intermediate care facility for the intellectually disabled. **This must be an original signature; signature stamps are not acceptable.** If the physician does not deem this applicant appropriate for institutional care, enter N/A and sign.

Item 26: Date Signed by the Physician
Enter the date the physician signs the form.

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

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 boxes only)

This section may be completed by the Katie Beckett child's Primary Care Physician or a registered nurse who is well aware of the child's condition.

Items 29—38: Check each appropriate box.

Item 39: Other Therapy Visits
If applicable, check the appropriate box for the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.

Item 40: Remarks
Enter additional remarks if needed or "None".

Item 41: Pre-admission Certification Number
Leave this item blank.

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

Item 43: Print Name of MD or RN/Signature of MD or RN
The individual completing Section C should print their name legibly and sign the DMA-6(A).
This must be an original signature; signature stamps are not acceptable.

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

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

PEDIATRIC DMA 6(A)
PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:

DFCS County_____

_____
Mailing Address

2. Medicaid Number:

3. Social Security Number

4. Sex | Age | 4A. Birthdate

5. Primary Care Physician

6. Applicant's Telephone #

7. In the caretaker's opinion, would the child require institutionalization if the child did not receive community services? ☐ 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 Department of Community Health and the Department of Human Resources, 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**

Name	Dosage	Route	Frequency

15. **Diagnostic and Treatment Procedures**

Type	Frequency

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

Previous Hospitalizations:_____ Rehabilitative/Habilitative Services:_____ Other Health Services:_____

Hospital Diagnosis: 1)_____ 2) Secondary_____ 3) Other_____

17. Anticipated Dates of Hospitalization: _____/_____ /

18. Level of Care Recommended: ☐ Nursing Facility ☐ ICF/ID 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 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, or ICF/ID

_____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 Status
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age > 3 ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP) ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/day ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old wheel chair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile
34. Integument System	**35. Urogenital**	**36. Surgery**	**37. Therapy/Visits**	**38. Neurological Status**
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits	40. Remarks
☐ Five days per week ☐ Less than 5 days per week	

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/habilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No ☐ NA	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	

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name: _____ DOB: _____ SS#_____
Diagnosis: _____
_____

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

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 __
Nurse in attendance during school day: _____ N/A ____ (Attach most recent 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 or facililty whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

Physician's Signature: _____ Date: _____
Primary Caregiver Signature: _____ Date: _____

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

1/2018

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. It may be completed by physician and the primary caregiver.

Member (Applicant) Information

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

Diagnosis

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

Level of Care

Check the correct box for the recommended level of care.

Medical History

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

Current Needs

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

Therapy

Therapies require a plan of care. All therapies, including school based therapies, must be ordered by a physician and accompanied by current individually signed therapy notes.

Hospitalizations

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

School

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

Signature

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

Instructions for Completing the Katie Beckett Cost Effectiveness Form

DMA Form 704

This form should be completed by the Katie Beckett child's primary physician.

Instruct the physician to complete the form as follows:

- Patient Name – Enter the name of the Katie Beckett child.
- The MES may provide the Medicaid number, if not known.
- 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.
- 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 the everything applicable, it is permissible to have other medical service amounts entered by the providing agency, pharmacy or therapist; have that entity initial next to the dollar amount; at the very least, the physician must complete the cost of his/her services.
- The physician must indicate if home care will be as good as institutional care.
- 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.
- The form must have an original signature of the primary care physician.
  Stamped signature are not acceptable. The date should be the date of the signature.

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

Department of Community Health

DCH Centralized Katie Beckett Unit

All therapies whether in school or private setting must be medically necessary.

Please provide supporting documentation:

- Current individual signed and dated therapy notes for the last 90 days.
- Signed physician orders for all therapies, specifying how many times per week each therapy service is medically necessary.

Failure to provide the supporting documentation by the time requested may result in the closure of your Katie Beckett Medicaid case or denial of your Katie Beckett Medicaid application.

Supplemental Evaluation Documents

DEVELOPMENTAL EVALUATION (Current no more than 3 years old)

Required for all Children with Developmental Delays-**Ages 0 to 5** such as ones listed below:

Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder, or other Developmental Delays.

Licensed Professionals approved to perform Developmental Evaluations are as follows:

- **Developmental** Pediatricians
- Psychologist with:
    - Ph.D
- School Psychologist, Preschool Diagnosticians, and Education Diagnosticians with the following degrees:

    M.Ed M.A CAS Psy.S SSP
    Ed.S M.S CAGS Psy.D Ed.D

EIS-Early Intervention Specialist with Babies Can't Wait are accepted for children with an individual Family Service Plan (IFSP). Also, an IFSP or/and Individualized Family Service Plan (IEP) must be submitted if in place.

The Developmental report MUST be signed by an approved Evaluator and Must contain:
STANDARD SCORES or **AGE EQUIVALENTS** in these **FIVE DOMAINS OF FUNCTION**:

COGNITION, LANGUAGE, MOTOR, ADAPTIVE, and SOCIAL

PSYCHOLOGICAL EVALUATION (Current no more than 3 years old)

Required for all Children with Developmental Delays-**Ages 6 to 18** such as ones listed below:

Cerebral Palsy, Epilepsy Cerebral, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder, or other Developmental Delays.

Licensed Professionals approved to perform Developmental Evaluations are as follows:

- **Developmental** Pediatricians
- Psychologist with:
    - Ph.D

- School Psychologist, Preschool Diagnosticians, and Education Diagnosticians with the following degrees:

    M.Ed M.A CAS Psy.S SSP
    Ed.S M.S CAGS Psy.D Ed.D

The Psychological report **M**UST be signed by an approved Evaluator and **MUST** contain an **IQ** score **AND Adaptive Function testing including an overall Composite Score**.

A current Psychological or Developmental Evaluation is always required when the recommended Level of Care (LOC) is ICF/MR and/or the Behavioral Status, (#33 on form DMA-6A) is anything other than alert and/or cooperative.

Revised 6/2023

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) 657-9761 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

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) 657-9761 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.

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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.

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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.

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Privacy Officer. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

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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

STATE OF GEORGIA APPLICATION FOR VOTER REGISTRATION

Fill out the bottom half of this application by following these directions. Print clearly and use blue or black ink.

1. **LEGAL NAME.** Your full legal name including any suffix such as Sr., Jr., III, is required on this form.
2. **ADDRESS.** Provide residential address. This information is required.
3. **MAILING ADDRESS.** If mailing address is different from residential address, complete the mailing address section.
4. **PERSONAL INFORMATION.** A telephone number is helpful to registration officials if they have a question about your application. Gender and race are requested and are needed to comply with the Voting Rights Act of 1965, but are not mandated by law.
5. **VOTER IDENTIFICATION NUMBER.** Federal law requires you to provide your full GA Drivers License number or GA State issued ID number. If you do not have a GA Drivers License or GA ID you must provide the last 4 digits of your Social Security number. Providing your full Social Security number is optional. Your Social Security number will be kept confidential and may be used for comparison with other state agency databases for voter registration identification purposes. If you do not possess a GA Drivers License or Social Security number please check the appropriate box and a unique identifier will be provided for you.
6. **OATH.** Federal law requires that you answer the citizenship and age questions. Read the oath and sign your name. If you cannot complete this application unassisted because of physical disability or illiteracy, you must either sign or make your mark on the signature line, and the person assisting you MUST sign the signature space for person assisting voter.
7. **POLL OFFICER QUESTION.** Your willingness to be a poll worker will have no bearing on your application for registration.
8. **NAME/ADDRESS CHANGE.** Complete these sections to change the name or address of your current voter registration.
9. **MAP/DIAGRAM.** If you live in an area without house numbers and street names, please include a drawing of your location to assist us in locating your appropriate voting precinct.
10. **DELIVERY INSTRUCTIONS.** Verify that you have completed and signed the application. Enclose a copy of your ID if you are submitting this form by mail and registering for the first time in Georgia. Fold the application in half, remove the tape at the top, and press the edges together. The application is ready for you to mail (postage is prepaid) or deliver to your county voter registration office.
11. **You are NOT officially registered to vote until this application is approved.** You should receive a voter precinct card in the mail. If you do not receive this acknowledgement within two to four weeks after mailing this form, please contact your county voter registration office. You can find your poll location and other election information on the Secretary of State's website at www.sos.state.ga.us/elections.

REQUIREMENT: If you are submitting this form by mail and you are registering for the first time in Georgia, enclose a copy of one of the following with your application: A copy of a current and valid photo ID, a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address. Those who are entitled to vote by absentee ballot under the Uniform and Overseas Citizens Absentee Voting Act are exempt from this requirement.

Place copy of ID in pocket ⇩ | Trim copy of ID to size ⇩

COUNTY PRECINCT	MUNICIPAL PRECINCT	DISTRICT COMBO	DDS APPLICATION NO.	REGISTRATION NO.	CHANGE OF ADDRESS ☐ CHANGE OF NAME ☐ OTHER ____
		OFFICE USE ONLY			

1	LAST NAME	FIRST NAME	MIDDLE OR MAIDEN NAME	SUFFIX ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V			
2	RESIDENCE ADDRESS: House No. and street name	APT NO.	CITY	COUNTY	STATE GA	ZIP CODE	
3	MAILING ADDRESS (If different from residence address): Post-office box or route		CITY		STATE	ZIP CODE	
4	TELEPHONE NUMBER ( )	DATE OF BIRTH: MM/DD/YYYY	GENDER Male ☐ Female ☐	RACE / ETHNICITY: ☐ Black ☐ White ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ American Indian ☐ Other ____			
5	VALID GA. DRIVER'S LICENSE OR GA. I.D. NO.	If no GA. Driver's License or GA. I.D. No., must provide last 4 digits of your Social Security Number	FULL SOCIAL SECURITY NUMBER (OPTIONAL) Last 4 digits (Required)	☐ Check if you do not have a GA Driver's License, GA. I.D. No. or Social Security No.			

6

(Your answer is required under federal law)

I SWEAR OR AFFIRM:

Are you a citizen of the United States of America? Check One Yes ☐ No ☐

Will you be 18 years of age on or before election day? Check One Yes ☐ No ☐

If you checked "No" in response to either of these questions, do not complete this form.

I SWEAR OR AFFIRM THAT:

I reside at the address listed above.
I am eligible to vote in Georgia.
I am not serving a sentence for having been convicted of a felony involving moral turpitude.
I have not been judicially declared to be mentally incompetent.

WARNING: Any person who registers to vote knowing that such person does not possess the qualifications required by law, who registers under any name other than such person's own name, or who knowingly gives false information in registering shall be guilty of a felony.
O.C.G.A. § 21-2-561

Date _____ X Signature _____ Signature of person helping illiterate or disabled voter _____

7 May we contact you about working as an Election Day poll officer: Yes ☐ No ☐

If you would like to receive additional information by email, please provide your e-mail address:

8 CHANGE OF NAME: If you are changing your name, list the name under which you were previously registered: Last Name Suffix First Middle or Maiden Name

CHANGE OF ADDRESS: If you are changing your address or if you were previously registered to vote, list your previous address:

CITY | COUNTY | STATE

Military Active Duty? Yes ☐ No ☐

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 19242 ATLANTA GEORGIA
POSTAGE WILL BE PAID BY ADDRESSEE

HON. BRIAN P. KEMP
SECRETARY OF STATE
STATE OF GEORGIA
PO BOX 105325
ATLANTA GA 30348-9562

STATE OF GEORGIA APPLICATION FOR VOTER REGISTRATION

If you meet the following qualifications, complete this form and **personally mail** to the Secretary of State or **personally** deliver to your county voter registration office. Prepaid postage is provided for your convenience.

QUALIFICATIONS: To register to vote you must:

- Be a **citizen** of the **United States**
- Be a legal **resident** of the **county**
- Be at least **17½** years of age to register and **18 to vote**
- **Not** be serving a sentence for conviction of a **felony** involving moral turpitude
- Have **not** been found **mentally incompetent** by a judge

See other side for complete instructions.

Once you complete and personally mail or deliver your application, you should receive an acknowledgement from the local voter registration office. Generally this process takes two to four weeks. To follow up on your voter registration application or to obtain more information on voter registration and elections, just call your local voter registration office.

GENERAL INFORMATION:
For more information on election dates, registration deadlines, and local county voter registration telephone numbers, see the Secretary of State's website at WWW.SOS.STATE.GA.US/ELECTIONS.

HON. BRIAN P. KEMP
SECRETARY OF STATE
1104 West Tower
2 Martin Luther King, Jr. Dr.
SE Atlanta, Georgia 30334-1505
Telephone: (404) 656-2871