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Title 42: Public Health
PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA
Subpart C—Options for Coverage

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§435.225 Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

(a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.

(b) If the agency elects the option provided by paragraph (a) of this section, it must determine, in each case, that the following conditions are met:

(1) The child requires the level of care provided in a hospital, SNF, or ICF.

(2) It is appropriate to provide that level of care outside such an institution.

(3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

(c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

[55 FR 48608, Nov. 21, 1990]

PEDIATRIC
NURSING FACILITY LEVEL OF CARE

Level of care criteria are based on definitions and guidelines derived from the Federal regulations and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and medically necessary services and is not diagnosis specific.

Summary:

1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*. With respect to an individual who has a mental illness or intellectual disability, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.
2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.
3. A nursing facility level of care is indicated if the conditions of Column A are satisfied in addition to the conditions of Column B being satisfied. Conditions are derived from 42 C.F.R.409.31– 409.34.
4. Some examples of those cases which may meet Nursing Facility Level of Care Criteria are as follows:
   a. Severely Medical Fragile Child as they may meet the criteria in Column A, 1, and I, 2, b and possibly others under 2 depending on the individual child plus Column B. Examples of children in this category include the child with Spina Bifida who has been hospitalized 3 or more times in the past year for shunt infection/malfunction or Urinary Tract Infections or a child with Poorly Controlled Type I Diabetes requiring hospitalization 3-4 times per year. These are ONLY examples and other cases may qualify in this category.
   b. Child with Cystic Fibrosis if they are receiving oxygen 5-7 days a week intermittently or continuously and/or the child has to be hospitalized 3-4 times per year for Cystic Fibrosis exacerbations which may meet the criteria in Column A, 1, and I, 2, b, j and Column B.
   c. Child with Osteogensis Imperfecta Type 2 and 3. A child with Type 2 has the most severe form which is frequently lethal and the child has numerous fractures with severe bone deformity. Type 3 has bones that fracture easily and possible respiratory problems. This child may meet the criteria in Column A, 1, and 2, b, k and II (possibly a-e) and Column B.
   d. Child who is medically unstable awaiting organ transplant and/or is in post-op period for one year post transplant. This child may meet the criteria in Column A, 1, and I, 2, b, and possibly others under 2 depending on the individual child plus Column B. This child may meet hospital level of care while in hospital for transplant. Once the child is stable post-transplant he/she no longer meets nursing facility level of care criteria.
   e. Children born at 26 weeks or less gestation. These children are at high risk of complications due to prematurity and are in the NICU at the beginning of life. These children may meet hospital level of care criteria while hospitalized and nursing facility level of care once discharged. The child may meet multiple criteria in Column A and B depending on the medical needs of the child and may initially be approved for up to six months and then re-evaluated.
   f. Child with Hemophilia: who is receiving IV Factor 8 on a 2-3 times/month schedule; or who has documented antibodies to Factor 8 (high risk for bleeding); or who exhibits chronic joint syndrome or a head bleed which requires an aggressive rehabilitation program. The child may meet multiple criteria in Column A and B depending on the medical needs of the child.
   g. Child with Sickle Cell: who is receiving chronic transfusions of 1-2 per month; or is admitted to the hospital with acute chest syndrome 2 or more times per year; or who is in pain crisis requiring hospitalization 3 or more times per year; or who has had a stroke and is involved in an aggressive rehabilitation program. The child may meet multiple criteria in Column A and B depending on the medical needs of the child.
   h. Child with Spina Bifida: Any child born with meningomyelocele, the most severe form of Spina Bifida, for one year after birth. (All of these children will at least require some surgical correction on the spine, most will require shunting, and most of their complications such as shunt malfunctions will occur in that 1st year). After the first year, any child with myelomeningocele may meet criteria if they have a medically severe combination of impairments documented by their physician which includes at least 4 of the following: (1) shunted hydrocephalus; (2) neurogenic bladder/bowel; (3) requirements for integument (skin) system intervention for a stage 2 or > decubiti (bedsore) by licensed health care workers within last 6 months (4) substantial limitations in physical mobility with at minimum being wheelchair bound; (5) substantial limitations in adaptive functioning as evidenced by a score on a standardized adaptive functioning tool of 2 standard deviations below the norm in 3 or more of any of the following behavior domains: self-care skills, understanding and use of verbal and nonverbal language learning in communication with others, mobility, self-direction, and

ageappropriate ability to live without extraordinary assistance; and/or (6) rehabilitation needs/therapeutic activities/exercises performed by licensed personnel 5 times per week.
Or after the first year, 3 or more hospitalizations for Spina Bifida related problems (i.e. shunt malfunction, urosepsis, orthopedic surgeries, or urological surgeries) in the preceding year.

COLUMN A	COLUMN B
1. The service needed has been ordered by a physician. 2. The service will be furnished either directly by, or under the direct supervision of, appropriately licensed personnel. 3. *The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.*	The individual requires service which is so inherently complex that it can be safely and effectively performed only by, or under the supervision of, technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, and speech pathologists or audiologists, **AND** In addition to the condition listed above, one of the following subparts must be met: **1. The *service* is one of the following or similar and is required seven days per week** a. Overall management and evaluation of a care plan for an individual who is totally dependent in all activities of daily living b. Observation and assessment of an individual's changing condition because the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior c. Intravenous or intramuscular injections or intravenous feeding d. Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day e. Nasopharyngeal or tracheostomy aspiration f. Insertion and sterile irrigation or replacement of suprapubic catheters g. Application of dressings involving prescription medications and aseptic techniques h. Treatment of extensive decubitis ulcers or other widespread skin disorder i. Heat treatments as part of active treatment which requires observation by nurses j. Initial phases of a regimen involving administration of medical gases k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment **OR** **2. The *service* is one of the following or similar and is required five days per week:** a. Ongoing assessment of rehabilitation needs and potential: services concurrent with the management of a patient care plan b. Therapeutic exercises and activities performed by PT or OT c. Gait evaluation and training to restore function to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality d. Range of motion exercises which are part of active treatment of a specific condition which has resulted in a loss of, or restriction of mobility e. Maintenance therapy when specialized knowledge and judgment is needed to design a program based on initial evaluation f. Ultrasound, short-wave, and microwave therapy treatment

	g. Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool treatment when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgment is required h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing **OR** 3. **The *service* is one of the following only if an additional special medical complication requires that it be performed or supervised by technical or professional personnel:** a. Administration of routine medications, eye drops, and ointments. b. General maintenance care of colostomy or ileostomy c. Routine services to maintain satisfactory functioning of indwelling bladder catheters d. Changes of dressings for non-infected postoperative or chronic conditions e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems. f. Routine care of incontinent individuals, including use of diapers and protective sheets g. General maintenance care (e.g. in connections with a plaster cast) h. Use of heat as a palliative and comfort measure (e.g. whirlpool and hydrocollator) i. Routine administration of medical gases after a regimen of therapy has been established j. Assistance in dressing, eating, and toileting k. Periodic turning and positioning of patients. l. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs.

Level of care criteria are based on definitions and guidelines

INTERMEDIATE CARE FACILITY (ICF/ID) LEVEL OF CARE

Level of care criteria are based on definitions and guidelines derived from the Federal regulations and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and medically necessary services and is not diagnosis specific.

Summary:

1. ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.
2. An ICF/ID level of care is generally indicated if the conditions of Column A, Column B, and Column C are satisfied. Conditions derived from 42 C.F.R. 440.150, 435.1009, and 483.440(a).
3. Column B refers to "an aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services." These active treatment services, as defined in 42 C.F.R. 483.440, provide aggressive, consistent monitoring, supervision and/or assistance as defined in the plan of care to address the specific medical conditions, developmental and behavioral needs, and/or functional limitations identified in the comprehensive functional assessment. This comprehensive functional assessment must be age appropriate.
4. The following conditions meet ICF/ID institutional level of care criteria, as these individuals would be institutionalized regardless of ability to participate in an aggressive program of specialized and generic training, treatment, health services, and related services as outlined in Column B: □ Those children with an IQ of 50 or below (moderate to profound intellectual disability) or
   - □ Those children who meet the criteria for Autism, Autism-Spectrum, Asperger's, Pervasive Developmental Disorder, Developmental Delay, Intellectual Disability, Down's Syndrome, and any other Developmental Disability as evidenced by:
     - i. a score on a standardized adaptive functioning tool of 2 standard deviations below the norm in three or more of any of the following behavior domains: self care skills, understanding and use of verbal and nonverbal language learning in communication with others, mobility, self-direction, and age-appropriate ability to live without extraordinary assistance or an overall standard score < 70, or
     - ii. if their age equivalency composite score is less than 50% of their chronological age, and/or
     - iii. the child has a Childhood Autism Rating Scale (CARS) score of above 37, a Gilliam Autism Rating Scale (GARS) of 121 or greater, or any other equivalent standardized assessment tool which indicate severe autism.

COLUMN A	COLUMN B	COLUMN C
1. The services have been ordered by a licensed physician. AND 2. The services will be furnished either directly by, or under the direct supervision of, appropriately qualified providers. AND 3. The services, as a practical matter, would have ordinarily been provided in an ICF-ID, in the absence of community services.	On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards: a. The acquisition of the skills necessary for the individual to function with as much selfdetermination and independence as possible; and b. The prevention of further decline of the current functional status or loss of current optimal functional status. This is evidenced by the Plan of Care by the individual's participation (at least five (5) days per week) in interventions which are required to correct or ameliorate the conditions/ diagnosis; and are compatible with acceptable professional practices in lights of the condition(s) at the time of treatment. Active treatment does not include: • interventions that address age-appropriate limitations; or • general supervision of children whose age is such that supervision is required by all children of the same age or • physical assistance for persons who are unable to physically perform tasks but who understand the process needed to do them.	1. The individual has an intellectual disability. OR 2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. OR 3. The individual has a condition, *other than mental illness*, (i.e. Autism, Autism-spectrum, Asperger's, Pervasive Developmental Disorder, Down's Syndrome or Developmental Delay) which is found to be closely related to an intellectual disability because it is likely to last indefinitely, and requires similar treatment and services. AND 4. The impairment for those conditions outlined above constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following functional limitations: • Self-care skills such as feeding, toileting, dressing and bathing; • Understanding and use of verbal and nonverbal language learning in communication with others; • Mobility; • Self-direction in managing one's social and personal life and the ability to make decisions necessary to protect one's self as per age-appropriate ability; and/or • Age-appropriate ability to live without extraordinary assistance.

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

PEDIATRIC DMA 6(A)

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:	2. Medicaid Number:	3. Social Security Number
Name: _____	_____	4. Sex Age 4A. Birthdate
Address: _____		
_____	5. Primary Care Physician: _____	
DFCS County: _____	6. Applicant's Telephone # _____	

7. Does guardian think the applicant should be institutionalized? ☐ Yes ☐ No	8. Does child attend school? ☐ Yes ☐ No	9. Date of Medicaid Application ____/____/____

Name of Caregiver #1: _____ Name of Caregiver #2: _____

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

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

Section B – Physician's Report and Recommendation

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

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

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

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

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

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

17. Anticipated Dates of Hospitalization: _____	18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation:	20. Patient Transferred from (check one):	21. Length of Time Care Needed ____ Months	22. Is patient free of communicable diseases?
☐ Initial ☐ Change Level of Care ☐ Continued Placement	☐ Hospital ☐ Another NF ☐ Private Pay ☐ Lives at home	1) ☐ Permanent 2) ☐ Temporary_____estimated	☐ Yes ☐ No

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

24. Physician's Name (Print): _____

Physician's Address (Print): _____

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

_____ **Physician's Signature**

26. Date signed by Physician ____/____/____

27. Physician's Licensure No. _____

28. Physician's Telephone #: _____

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

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral S tatus
☐ Regular ☐ 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 years ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/days ☐ 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 years ☐ 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 services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No	46A. State Authority MH & MR Screening Level I/II Restricted Auth. Code Date 46B. This is not a re-admission for OBRA purposes
47. Hospitalization Precertification ☐ Met ☐ Not Met	Restricted Auth. Code Date

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

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

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

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

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 (except items 2 and 9) should be completed by the parent or the legal representative of the child.

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

Item 2: Medicaid Number
To be entered by the Medicaid Eligibility Specialist (MES).

a. If the child is in the Medicaid System, the Medicaid Number will be the 12-digit number from GAMMIS, e.g., 111222333444.
b. If this is a new application for the child the Medicaid Number will be the 9-digit client number from SUCCESS plus a "P", e.g., 123456789P.

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

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

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

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

Item 7: Does the guardian think the applicant should be institutionalized?
If the child were not eligible under the Katie Beckett program, would s/he be appropriate for placement in a nursing facility, hospital or institution for the mentally retarded. Check the appropriate box.

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

Item 9: Date of Medicaid Application
To be entered by the Medicaid Eligibility Specialist (MES).

Fields below Item 9:
Enter the name of the primary caregiver for the child. If a secondary caregiver is available to care for the child, indicate the name of the caregiver.

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

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

Item 11: Date
Enter the date the 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 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 child'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 child's condition on the appropriate lines. Enter the ICD code. Depending on the diagnosis, a psychological evaluation may be required. If an evaluation has been completed within the past three years, include a copy with this packet.

Item 14: Medications (Add attachment(s) for additional medication(s))
List the name of all medications the child is to receive. Include the name of drugs with dosages, routes, and frequencies of administration.

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

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative and other health care services the child 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 child.

Item 17: Anticipated Dates of Hospitalization
List any dates the child may be hospitalized in the near future for services. Enter N/A if not applicable.

Item 18: Level of Care Recommended
Check the correct box for the recommended level of care; hospital, nursing facility, or intermediate care facility for the mentally retarded. If left blank or N/A is entered, it is assumed that the physician does not deem this child appropriate for institutional care. Level of care recommendation and approval are requirements for the Katie Beckett program.

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

Item: 20: Patient Transferred from (Check one)
Indicate if the child 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 child will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Check in the appropriate box.

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

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

Item 25: Certification Statement of the Physician and Signature
The admitting or attending physician must certify that the child requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. **This must be an original signature; signature stamps are not acceptable.** If the physician does not does not deem this child 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 Georgia license number for the attending or admitting physician.

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

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

This section may be completed by the child's primary care physician or a registered nurse who is well aware of the child's condition.

Items 29--38: Complete each item as indicated.

Item 39: Other Therapy Visits
If applicable, indicate 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; stamps are not acceptable.**

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

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

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

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

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

Current Needs

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

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

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

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

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

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

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

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
All therapies, including school based therapies, must be ordered by a physician and accompanied by a plan of care. Current therapy notes must be attached.

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.

TEFRA/Katie Beckett

Cost-Effectiveness Form

(Child's physician must complete Form)

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

Patient's Name:_____ Medicaid #:_____

Diagnosis:_____

Prognosis:_____

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

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

TOTAL $_____

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

_____ Yes _____ No

COMMENTS:

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE _____

DATE: _____

DMA Form 704
Rev. 10-04

Instructions for Completing the Katie Beckett Cost-Effectiveness Form

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

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

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_____

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.

Nathan Deal, Governor

Keith Horton, Commissioner

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

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Effective Date: August 15, 2013

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

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

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

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

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

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

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

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

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

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

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

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

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

SPECIAL SITUATIONS:

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

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

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform billing services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

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

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

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

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

YOUR RIGHTS:

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

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

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

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

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

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

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid "out-of-pocket" in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

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

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

CHANGES TO THIS NOTICE:

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

COMPLAINTS:

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

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

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

_____ _____

Signature Date

_____

Print Name

_____ _____

Signature Date

_____

Print Name

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

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept

Check block(s) that apply to you:

- ☐ Pregnant Woman
- ☐ Families w/Children – LIM
- ☐ Child(ren) Only – RSM
- ☐ Chafee Independence Program Medicaid

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

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

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

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

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

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

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

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

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

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

INCOME, RESOURCES and DAYCARE

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

Income	Gross Amount per Pay Check (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving		Resources	Amount in Account/Value	Who Owns Resource?
Wages/Earnings					Cash		
Current Employer:					Checking Account		
Wages/Earnings					Savings Account		
Current Employer:					Credit Union		
Social Security Income/SSI					401K/Retirement Account		
Worker's Compensation					Other		
Pensions or Retirement Benefits					**Vehicle(s):** Cars, trucks, motorcycles (licensed)		
Child Support/ Contributions					Make / Model / Year / Amount Owed?		
Unemployment Benefits							
Other Income, please specify:							

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

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

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

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

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

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

Signature (Required): _____ Date: _____

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

August 01, 2015

**** Important Requested Information Update *******

For School and Private Based Therapy Sessions:

*** Please provide individual signed therapy notes for the last 90 days**
*** Please provide current evaluations for speech, occupational and physical therapy**
*** Please provide signed physician orders for all therapy sessions.**

Failure to provide this by the time requested will result in closure of your Katie Beckett Medicaid case or your Katie Beckett application

If you have any questions please feel free to contact KB Supervisor, Niyokia Sermons at 678-248-7465 or via email NSermons@dch.ga.gov

Sincerely,

Niyokia Sermons

The Following Evaluations Are Required for Children With Developmental Delays

Psychological Evaluation

Required for children with developmental delays such as the ones listed below: Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays.

Licensed Professionals with the following credentials should sign these documents:

- **Developmental Pediatrician**
- **Psychologist**
- **Ph.D**
- **M.Ed**
- **Ed.S**
- **Ed.D**

The Report must contain an IQ score, Adaptive function testing including an overall composite score (Required for all children with Developmental Delays (Ages 6 to 18)

Developmental Evaluation

Required for children with developmental delays such as the ones listed below: Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays.

Licensed Professionals with the following credentials should sign these documents:

- **Developmental Pediatrician**
- **Psychologist**
- **Ph.D**
- **M.Ed**
- **Ed.S**
- **Ed.D**
- **Early Interventionist with Babies Can't Wait**

The report must contain standard scores or age equivalents in the five domains of function: Cognition, Language, Motor, Adaptive and Social (Children Ages 0-5)

***The Current Psychological or Developmental Evaluation cannot be more than 3 years old.**

CITIZENSHIP/IDENTITY VERIFICATION CHECKLIST

AU NAME: _____

AU NUMBER: _____

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

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

No Identity Required on these Citizenship Verifications:

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

Identity Required with these Citizenship Verifications:

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

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

Acceptable Verification of Identity:

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

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

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

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

HIPP UNIT – 900 Circle 75 Parkway, Suite 650, Atlanta, GA 30339 Tel: (678) 564-1162 Fax: (800) 817-1769

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) Program

Head Of Household:	Referral Source:
Address:	Address:
City: State	City: State:
Zip: Tel. #	Zip: Telephone #:

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

Policy holder's name:_____ Insurance Co. name: _____
Policy number:_____ Insurance Co. address:_____
Group number: _____ City/State/Zip:_____
Policy holder's SSN:_____ Telephone #: _____
Policy holder's date of birth:_____

2. What is the annual Maximum Out of Pocket Expense for the: Individual?_____ Family?_____

3. Is the annual deductible included in the out of pocket expense? YES___ NO_____

4. If no, what is the annual deductible: Individual?_____ Family?_____

5. Is this policy an HMO or PPO? YES___ NO_____

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

Employer name: _____ Employer address:_____
Employer telephone:_____ City/State/Zip:_____

7. 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.		/ /			

8. Are any of these persons pregnant? Yes_____ NO_____ If yes:

Name **Expected Date of Delivery** **Name** **Expected Date of Delivery**
_____/_____/_____ _____/_____/_____

9. Have any of the persons in #7 above been diagnosed with a medical condition? If yes, please list all medical conditions or diagnosis (use back of application for additional space).

Name **Condition**
YES _____ **NO** _____
_____

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

Paid: ☐ WEEKLY ☐ BIWEEKLY ☐ SEMIMONTHLY ☐ MONTHLY ☐ QUARTERLY ☐ OTHER

11. If known, check the services covered under this policy?

☐ HOSPITAL ☐ PHYSICIAN ☐ DENTAL ☐ DRUG ☐ HOME HEALTH ☐ LONG TERM CARE

12. Complete the following information if COBRA benefits might 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)**

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

14. 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: **Ins. Company, if applicable:**
_____ _____

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

_____ _____
Signature of applicant **Date**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS FOR COMPLETION OF APPLICATION FOR THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM
PLEASE READ CAREFULLY

Head of Household

Provide the name of the head of household and address and telephone number where he or she may be reached 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, the policyholder's social security number and date of birth. We can not process the application without the social security number of the policyholder. BOTH the insurance policy number, if applicable, and group number, if applicable, address and telephone number of the insurance company. The telephone number should be the number for the insurance company's customer service department. 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 policyholder's direct phone number.** We will need to verify information with the employer and not the policyholder. Please provide the same information if the policy holder is self employed. If this is a non-group policy, please attach copy of current billing statement for premium verification. Providing this information with the application will expedite the verification process.

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, include the additional information on back of the application.

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 the health 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 company. If you do not have access to the insurance company 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. Please attach a copy of the COBRA enrollment packet to this application. This information is needed to determine if the HIPP Program can assist with the premium payments for the COBRA plan.

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
900 Circle 75 Parkway
Suite 650
Atlanta, GA 30339

Should you have any questions, you may contact the HIPP Unit directly at 678-564-1162.

ORDER OF MEDICAL NECESSITY FOR SERVICES

The following services are physician ordered and medically necessary for my patient, XXXXX XXXXXX.

Medicaid #: applying for

DOB X-XX-XXXX

Speech Therapy at school	**3 times per week/360 minutes monthly**
Occupational Therapy at school	**30 minutes weekly**
Physical Therapy at school	**60 minutes monthly**
Behavioral Therapy	**2 @ 3 hours per week**

***Additional therapies listed below have been ordered but XXXX is not yet receiving due to costs. He requires the TEFRA Katie Beckett Deeming Waiver in order to receive these additional medically necessary private therapies.**

Speech Therapy Privately	**Three times weekly @ 60 minutes***
Occupational Therapy Privately	**One Time weekly @ 60 minutes***
Physical Therapy Privately	**One time weekly @ 60 minutes***

_____ _____

Physician's Signature **Date**