Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

(QMB - payment of premiums, coinsurance, and deductibles;
SLMB - payment of Part B premium; **and QI-1** - payment of Part B premium**)**

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)
   _____
   _____
   _____
   ATTN: _____
3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial)	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial)
Mailing Address	
Street Address	Mailing Address
City State Zip Do you own/are you purchasing home? ☐ Y ☐ N	City State Zip
Phone County E-Mail Address	Phone E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Maiden/other name(s):	Birthdate	Sex	Race	U.S. Citizen (Yes or No)	Social Security Number	Marital Status
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? ☐ **Yes** ☐ **No**

Are you blind or disabled? ☐ **Yes** ☐ **No** - Is your spouse blind or disabled? ☐ **Yes** ☐ **No**

LIVING ARRANGEMENT: Check the box(es) that best describes your current situation.

Living In Own Home	Nursing Facility	Another's Home	Hospice	Hospital	Katie Beckett	Community Care	Assisted Living	Other/ Renting
	Date Admitted:			Date Admitted:		Date Admitted:		

HEALTH INSURANCE:

Do you have Medicare? ☐ **Yes** ☐ **No** Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ **Yes** ☐ **No**	Type of Coverage ☐ **Part A** ☐ **Part B** (hospital) (doctor) ☐ **Part D** (RX)	Effective Date: _____ Medicare Number: _____	Have you ever received SSI? ☐ **Yes** ☐ **No** If so, when did it end?_____
Does your spouse have Medicare? ☐ **Yes** ☐ **No**	Type of Coverage ☐ **Part A** ☐ **Part B** ☐ **Part D**	Effective Date: _____ Medicare Number: _____	Has your spouse ever received SSI? ☐ **Yes** ☐ **No** If so, when did it end?_____

Do you have other health insurance? ☐ **Yes** ☐ **No**

Does your spouse have other health insurance? ☐ **Yes** ☐ **No**

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

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

REAL PROPERTY: Do you own all or part of any real estate in which you do not live?☐ **Yes** ☐ **No**
If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☐ **Yes** ☐ **No** If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?					
Checking account	☐ **Yes**	☐ **No**	Funeral plans/ prepaid burial item	☐ **Yes**	☐ **No**
Savings account	☐ **Yes**	☐ **No**	Burial plots or contracts	☐ **Yes**	☐ **No**
Government bonds	☐ **Yes**	☐ **No**	Stocks and bonds	☐ **Yes**	☐ **No**
Trust funds	☐ **Yes**	☐ **No**	Other (IRA, CD, promissory note, etc.)	☐ **Yes**	☐ **No**
Have you or your spouse given away any assets for less than its value?				☐ **Yes**	☐ **No**

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

Do you or your spouse have a life insurance policy? ☐ **Yes** ☐ **No**

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security	SSI	Wages/ Self-Employment
Railroad Retirement Benefits	Veterans' Benefits	Trust or Annuity Payments
Pensions/ Retirement Benefits	Rental Income Paid to You	Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)

Are you a veteran? ☐ **Yes** ☐ **No** Is your spouse a veteran? ☐ **Yes** ☐ **No**

Where did you and spouse work in the past? _____

Do you or your spouse have any unpaid medical bills ? ☐ **Yes** ☐ **No**

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) **As a condition of my eligibility, I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits).** I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I understand that Medicaid members who, are an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other mental institution that have their medical care paid by Medicaid will be subject to the Medicaid Estate Recovery Program. Additionally, Medicaid members who are 55 years of age or older and who receive home and community based services or are enrolled in and receive services through a waiver program are also subject to Estate Recovery. I acknowledge receipt of a written notice that medical assistance payments made on my behalf may be recovered from my estate after my death.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse or Representative:	**Date:**

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

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

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

CHILDREN SEEKING BENEFITS

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

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

_____ _____
SIGNATURE (PARENT/GUARDIAN) (DATE)

ADULT(S) SEEKING BENEFITS

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

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

_____ _____
SIGNATURE (PARENT/GUARDIAN) (DATE)

_____ _____
SIGNATURE (PARENT/GUARDIAN) (DATE)