FOR COUNTY USE ONLY: Date Received in County Dept	Georgia Department of Human Resources **MEDICAID REVIEW FORM**	**DATE DUE:**

AU#: Load#
Client's Name
Address

It is time for your Medicaid Review. Please complete the form and return or your Medicaid will stop.

1. Have you moved? ☐ No ☐ Yes
   If yes, give us your new address: _____

2. Please list all persons living with you. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid.

First Name	MI	Last Name	Date of Birth	Sex M/F	Is Medicaid requested for this individual? (Y/N)	Relationship to you	Social Security Number	Is this person a U.S. Citizen? (Y/N)

3. Is anyone pregnant? ☐ Yes ☐ No If Yes, Who? _____

4. Does anyone in the household have any unpaid medical bills? ☐ Yes ☐ No If yes, please send current bills.

5. Do you have other Health Insurance? ☐ Yes ☐ No If yes, send us a copy of your insurance card.

6. **Resources:** Check all resources (assets) owned by you, your spouse, your dependents, or any resources jointly owned with someone else. Attach additional pages if necessary.

Cash	❑Yes ❑No	Certificates of Deposit	❑Yes ❑No
Checking Accounts	❑Yes ❑No	Funeral Plans/Prepaid Burial	❑Yes ❑No
Savings Accounts	❑Yes ❑No	Burial Plots or Contracts	❑Yes ❑No
Credit Union Accounts	❑Yes ❑No	Stocks and Bonds	❑Yes ❑No
Annuities	❑Yes ❑No	Trust Funds	❑Yes ❑No
Government Bonds	❑Yes ❑No	Non-Home Place Property	❑Yes ❑No
Safety Deposit Box	❑Yes ❑No	Tax Refund	❑Yes ❑No
Retirement Accounts	❑Yes ❑No	Home Place Property	❑Yes ❑No
Vehicles	❑Yes ❑No	Life Insurance	❑Yes ❑No
		Other Resources	❑Yes ❑No

If you answered yes to any of these questions, please describe below and provide proof.

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

Revised Form 222 (Rev 02/08)

7. **Income and Earnings:** Check all income owned by you, your spouse, and your dependents, or any income jointly received with someone else.

Wages or Salaries	❑Yes ❑No	Tips or Commission	❑Yes ❑No
Disability or sick pay	❑Yes ❑No	Self-employment or Odd jobs	❑Yes ❑No
Unemployment Benefits	❑Yes ❑No	Severance Pay	❑Yes ❑No
Social Security Income	❑Yes ❑No	Interest or Dividends	❑Yes ❑No
Worker's Compensation	❑Yes ❑No	Veteran's Benefits	❑Yes ❑No
Pension or Retirement	❑Yes ❑No	Rental Property Income	❑Yes ❑No
Child support or Alimony	❑Yes ❑No	Military Allotments	❑Yes ❑No
Adoption Assistance	❑Yes ❑No	Foster/Relative Care Pay	❑Yes ❑No
Contributions from others	❑Yes ❑No	Other income (specify)	❑Yes ❑No

If you answered yes to any of these questions, please provide proof.
Complete the information below for every person working:

Person who works	Employer	How often paid

8. Does anyone pay child or dependent care cost? ☐ Yes ☐ No If yes, how much is paid and how often is it paid?

_____

9. Have you transferred or given away any assets or property in the past 60 months? ☐ Yes ☐ No
If yes, explain: _____

IMPORTANT: If your benefits change as a result of this review, we will send you a notice explaining what will happen. If you do not agree with our decision, you can request a fair hearing.

- I understand that if I am not satisfied with the action taken on my case, I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the county office where I applied.
- I understand that any lump sum or "windfall" payment that any person in my Medicaid case receives must be budgeted, along with any other income that we might have, to determine eligibility.
- I agree to provide the county and/or representative of the Department of Human Resources information necessary for verifying any statement given on this form and hereby give permission to the same to obtain verification of such information if needed.
- 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 such as banks, saving and loan associations, credit reporting bureaus, and other county, state, and federal government agencies, including Internal Revenue Service, to verify eligibility for assistance.
- **Assignment of Rights of Payment for Medical Support and other Medical Care:** 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. (If you are completing this form 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 above as a condition of his/her eligibility for Medicaid.)

PENALTY WARNING

I understand that: If I give false information or withhold information, I may be prosecuted for fraud.
I must also report all changes in my situation within 10 days of becoming aware of a change.

TO THE BEST OF MY KNOWLEDGE, I SWEAR OR AFFIRM THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT.

SIGN, DATE AND RETURN THIS FORM BY THE DUE DATE ON THE FRONT OF THE FORM

YOUR SIGNATURE OR MARK: _____ _____
Date

PHONE NUMBER: _____ E-MAIL ADDRESS: _____

SIGNATURE OF PERSON HELPING TO COMPLETE THIS FORM: _____ DATE: _____

DO YOU WANT THIS PERSON AS YOUR PERSONAL REPRESENTATIVE? ☐ Yes ☐ No

ADDRESS: _____ PHONE: _____