January 25, 2022

Sample Katie Beckett Medicaid Application

This sample completed application was created in conjunction with the 1/25/2022 virtual training. Please note, this is simply a sample application and there is no medical or legal advice being offered. The physician is responsible for many portions of the application, and they must determine the required needs of the child and medical level of care ordered. Please refer to the Department of Community Health Policy & Procedures Manual.

Parent to Parent of Georgia Website: www.p2pga.org

Debbie Dobbs Advocacy, LLC Website: www.debbiedobbs.com

John Doe
Your Mailing (Street) Address
Marietta, GA 30005
Phone: 888-888-8888
Email: emailme@gmail.com
January 10, 2022

Katie Beckett Medicaid Team
P.O. BOX 172
Norcross, GA 30091

Dear Sir/Madam:
Subject: Katie Beckett/Deeming Waiver Application for **Your child's name**.

The attached documents are part of Your child's name Katie Beckett Deeming waiver application. I have filled out all the forms and have attached the necessary documents. The enclosed document include:

Forms

1. Pediatric DMA 6(A)- Physician's Recommendation For Pediatric Care
2. DMA 706-TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
3. DMA 704- TEFRA/Katie Beckett Cost-Effectiveness Form
4. DMA 285-Georgia Department of Community Health-Third Party Liability Health Insurance
5. Information Questionnaire
6. Form 94-Medicaid Application
7. Form 216-Declaration of Citizenship/Alien Status
8. Form 5460 –Notice of Privacy Practices. Georgia Department of Human Resources
9. Form DMA 124-Application for Health Insurance Premium Payment (HIPP) Program

Supporting Documents

1. Attachments for DMA 6 (A), TEFRA/Katie Beckett Medical Necessity/Level of Care Statement Form DMA 706, Cost Effectiveness form DMA 704, DMA 285, DMA 124
2. Doctor's Order for Medically Necessary therapies
3. SSI Denial Letter
4. Copy of Birth Certificate
5. Copy of Social Security Card
6. Copy of School Psychoeducational Evaluation (or BCW Evaluation or Psychologist Evaluation)
7. Copy of IEP (or IFSP)
8. Copy of Behavior Intervention Plan
9. Copy of Oral Motor Evaluation
10. Copy of Behavior Consultant's Evaluation
11. Therapist's plan of care that includes present levels of functioning (OT, PT & SLP)
12. Copy of 90 days of OT, PT & SLP Signed Therapy notes (Both school and Private)
13. Copy of Private Insurance Card (Front & Back)
14. Copy of Hospital Discharge Summary
15. Copy of last 12 months of medical records from all medical providers (ONLY FOR INITIAL APPLICATIONS)

If you have any questions, please call or email me.
Sincerely,
John Doe

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
- ☐ Women's Health
- ☐ Child under 19
- ☐ Parent Caretaker
- ☐ Chafee Independence Program Medicaid

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

X **TEFRA/Katie Beckett Deeming Waiver**

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:
Your Child's First Name	K	Doe		01/10/2022

Mailing Address:	City:	State:	Zip Code:
Your Mailing Address	Marietta	GA	30080

Residence Address (if different from Mailing Address):	Phone Number(s):	E-mail Address:
Same as above	888-888-8888	needkbnow@gmail.com

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)	
Your Child's First Name	K	Doe	N/A	Asian	M	10/21/2010	Self	555-55-5555	Y		Y		Y	

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).

John	W	Doe	N/A	Asian	M	11/25/1980	Father		Y		Y		Y	
Jane	L	Doe	N/A	Asian	F	10/25/1981	Mother		Y		Y		Y	

Are you pregnant? ☐ Yes X No, Due Date: _____ Number expected _____. Are you able to have a baby? ☐ Yes X No. Have you ever delivered a baby weighing less than 2500 grams (5 pounds, 8 ounces)? ☐ Yes X No Have you delivered a baby weighing less than 1500 grams (3 pounds, 5 ounces) on or after January 1, 2011? ☐ Yes X No. *Do you have any unpaid medical bills from the past three months? X Yes ☐ No If yes, which months? Oct., Nov., December 2021 Are you currently covered by other Health Insurance? Are you currently on Medicaid? ☐ Yes X No If yes, list Insurance Company and policy number: Does anyone in the household have any private health insurance? X Yes ☐ No BC/BS Ins. 123456789

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

Form 94 (09/16)

*** If you want Medicaid to cover any unpaid bills, then mark Yes to that question and note the last three months prior to you application**

Katie Beckett Deeming Waiver

INCOME, TAX FILER and DEPENDENT CARE

List all income received by persons on page 1 of this application. Be sure to show the amount before deductions. Attach an extra sheet if necessary. We will decide, based on the type of Medicaid, whose income must be counted and whose may be excluded. **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
Wages/Earnings	If you have an SSI denial letter or if you are providing proof of SSI ineligibility		
Current Employer:	(i.e. paystubs, or tax returns, etc.) Then you do not have to fill out this section.		
Wages/Earnings	Also you would have to make sure your child doesn't have income or assets of more than $2000.00 in their name as this will disqualify them for **any** type of Medicaid.		
Current Employer:	So, if your child doesn't have any income or assets then write here.		
Social Security Income/SSI	"Katie Beckett Application-Child doesn't have income or assets"		
Worker's Compensation	"See Attached for Proof of SSI Ineligibility"		
Pensions or Retirement Benefits			
Child Support/ Contributions			
Unemployment Benefits			
Other Income, please specify:			

Tax Filer Information

1.Does anyone in the household plan to file a federal income tax return **NEXT YEAR?** ❑Yes ❑No

If **YES**, who? (List each person who plans to file)

2.Will any of the tax filers listed file jointly with a spouse? ❑Yes ❑No

If **YES**, please list spouses name:

_____

3.Will any of the filers claim any dependents on their tax return?

❑Yes ❑No If **YES**, please list the names of dependents: _____

_____

4. Will anyone be claimed as a dependent on someone else's return?

❑Yes ❑No If **YES, please list the name of the tax filer and the dependent:**

_____

_____

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

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
N/A	N/A	N/A	

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

Signature (Required): John Doe _____ Date: 01/10/2022 _____

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

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

Section A – Identifying Information

1. Applicant's Name/Address: Your Child's Name

DFCS County The County you live in

Your complete mailing address
Mailing Address

2. Medicaid Number:
If your child doesn't have Medicaid you can put "NEW APPLICATION"

3. Social Security Number
Your Child's SS #

4. Sex: M

Age: Your Child's Age

4A. Birthdate: Your Child's Birthdate

5. Primary Care Physician
Name of your Child's Pediatirican

6. Applicant's Telephone # Your Phone number

7. In the caretaker's opinion, would the child require institutionalization if the child did not receive community services? ☒ Yes ☐ No

8. Does child attend school? ☒ Yes ☐ No

9. Date of Medicaid Application 01 / 10 / 2022
*Do not date until your Dr. has signed the forms

Name of Caregiver #1: John Doe Name of Caregiver #2: Jane Doe

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

10. Signature: Signature of John Doe
(Parent or other Legal Representative)

11. Date: 01/10/2022

Section B – Physician's Report and Recommendation

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

*Please see attachment for more detailed information

13. Diagnosis

1) Autism 2) Down Syndrome 3) Cerebral Palsy
(Add attachment for additional diagnoses)

1. ICD	2. ICD	3. ICD
F84.0	Q90.9	G80.4

14. **Medications**

Name	Dosage	Route	Frequency
Imuran	50 mg	Oral	1 x per day
Zofran	8mg	Oral	1 x per day
* Please see attachment for additional medications			

15. **Diagnostic and Treatment Procedures**

Type	Frequency
*Please see attachment for more detailed information	

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

Previous Hospitalizations: Please see attachment Rehabilitative/Habilitative Services: Please see attachment Other Health Services: N/A

Hospital Diagnosis: 1) Please see attachment 2) Secondary Please see attachment 3) Other Please see attachment

17. Anticipated Dates of Hospitalization: N/A /
Put the date if you have an upcoming hospitalization if not, put N/A

18. Level of Care Recommended: ☐ Nursing Facility ☒ ICF/ID Facility
If you are applying under the ICF level of care then check that one, but if you child requires intensive Nursing care and you are applying under Nursing level then check that one. Most often ICF/ID is the more common level of care. Check the Level of Care infomration before you decide.

19. Type of Recommendation:
☒ Initial
☐ Change Level of Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☒ Lives at home

21. Length of Time Care Needed _____Months
1) ☒ Permanent
2) ☐ Temporary _____ estimated

22. Is patient free of communicable diseases?
☒ Yes ☐ No

23. This patient's condition could be managed by provision of ☒ Community Care or ☒ Home Health Services

24. Physician's Name (Print): Your Child's Dr.'s Name

Physician's Address (Print): Dr.'s address

25. I certify that this patient requires the level of care provided by a nursing facility, or ICF/ID
Dr.'s Signature Physician's Signature

26. Date signed by Physician: 01/10/2022

27. Physician's Licensure No.: Dr.'s licensure number

28. Physician's Telephone #: (888) 888-8888

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

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral Status
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT Meds Eats only pureed food	☐ Age Dependent Incontinence ☒ Incontinent - Age > 3 ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP) ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/day ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☒ Room Air	☐ Prosthesis ☒ Splints ☒ Unable to ambulate > 18 months old wheel chair ☐ Normal	☐ Agitated ☒ Cooperative ☒ Alert ☒ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile Hard time transitioning, screams, yells, elopes, hits family members

34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits	38. Neurological Status
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☒ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent –Age > 3 ☐ Catheterization ☒ Continent	☒ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☒ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☒ Seizures ☒ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits

☒ Five days per week ☐ Less than 5 days per week

40. Remarks

GARS -3 : Autism rating is 127 and IQ Score of 45 and Vineland-3 Composite is 55

41. Pre-Admission Certification Number

N/A

42. Date Signed

01/10/2022

43. Print Name of MD or RN: Dr.'s Name

Signature of MD or RN: Dr.'s Signature

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date:_____ Admission Date _____ Approved for _____Days or _____Months

45. Are nursing services, rehabilitative/habilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No ☐ NA

46A. State Authority MH & MR Screening)

Level I/II

Restricted Auth. Code Date

46B. This is not a re-admission for OBRA purposes

Restricted Auth. Code Date

47. Hospitalization Precertification ☐ Met ☐ Not Met

48. Level of Care Recommended by Contractor

☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

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

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name: Your Child's Name DOB: Child's birthdate SS# Your Child's Social Security Number
Diagnosis: F84.0 Autism, Cerbral Palsy, Down Syndrome *Please see attached for additional diagnosis

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

Medical History: (May attach hospital discharge summary or provide narrative):
Please see attachment

	None	Current Needs: Description of Skilled Nursing Needs
Cardiovascular:	X	
Neurological:		Absent & Drop Seizures-so requires full observation
Respiratory:	X	
Nutrition:		All food has to be pureed, at risk for aspiration with thin liquids, "Thick it" is used
Integumentary:		Eczema care and no pressure sores
Urogenital:	X	
Bowel:		Incontinent and due to Crohn's Disease has recurring Diarrhea and Constipation
Endocrine :	X	
Immune:		Due to Chron's takes immunosuppressive drugs-so caution must be excercised
Skeletal:	X	
Other:		Due to Autism needs ABA and Behavior services

Therapy (Attach current notes) : Speech sessions/wk 2 PT sessions/wk 2 OT sessions/wk 2
Autism Spectrum Services/wk 5 You note here what your child is **currently** receiving.

Hospitalizations within last 12 months: (Attach most recent hospital discharge summary)
Date: 12/12/2021 Reason: Crohn's Disease Duration: 12 days
Comments: Due to complications related to Crohn's, child was hospitalized. See attachment # 1

Child in school: YES Hrs per day 7.5 Days per wk 5 N/A ____ IEP/IFSP x
Nurse in attendance during school day: _____ N/A x (Attach most recent month's nursing notes)

Skilled Nursing hours received: Hrs/day _____ N/A x

I attest that the above information is accurate and this member meets Pediatric Level of Care Criteria and requires the skilled care that is ordinarily provided in a nursing facility or facililty whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

Physician's Signature: Dr.'s Signature Date: 01/10/2022
Primary Caregiver Signature: John Doe's Signature Date: 01/10/2022

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

DMA 706

January 10, 2022
Re: TEFRA/Katie Beckett application attachment for ***Your Child's Name*, DOB**: 10/21/2010

DMA 6(A) #12, History; Level of Care Statement, Medical History

Your child's Name was born full term but had complications at birth, due to lack of oxygen. He spent 12 days in the NICU and was discharged with an Apnea Monitor. Some chronic problems are recurrent ear infections which led to ear tubes and also caused hearing loss. Due muscle tightening Your child's name has had several Botox treatments and eventually underwent tibia osteotomy. Your child's name also was diagnosed with Crohn's disease and reflux and hence has a multitude of GI related issues and hospitalizations related to the manifestation of Crohn's disease. In short, your child's name has multiple medical problems including behavior disorders, severe global developmental disability and other diagnosis have been noted in other areas of this application.

DMA 6(A) #13, Diagnosis/additional diagnosis, with ICD-10 codes; Level of Care Statement; Cost- Effectiveness Form; DMA 285; DMA 124

Diagnosis	ICD 10 Codes
Autism	F84.0
Down Syndrome	Q90.0
Agenesis of the Corpus Callosum	Q04.0
Cerebral Palsy	G80.9
Global Developmental Delays	F88
Crohn's Disease	K50.90
Gastroesophageal Reflux Disease	K21.9
Dysphagia, Unspecified	R13.0
Sensorineural Hearing Loss-bilateral	H90.3
Recurrent Otitis Media	H65.07
Unspecified Disorder of Circulatory System	I99.9
Pressure Ulcers	L89.90
Sleep Disturbance	G47.9
Mixed Receptive/Expressive Language Disorder	F80.2
History of Food Allergy	Z91.01

DMA 6(A) #14; Medications:

Name	Dosage	Route	Frequency
Azathioprine	75 mg	Oral	75 mg Oral 1 x day
Zofran	8 mg	Oral	1 x day
Prednisolone			As needed per gastroenterology
Ciprodex Otic			As needed for ear discharge
Biafine Topical Emulsion			As needed for pressure sores
MiraLAX	17mg	Oral	1 x day
Lamotrigine	150 mg	Oral	2 x day

Dr. 's Signature

Dr.'s Typed Name

January 10, 2022
Re: TEFRA/Katie Beckett application attachment for ***Your Child's Name*, DOB**: 10/21/2010

DMA 6(A) # 15, Diagnostic and Treatment Procedures;

MRI	1 x per year
EEG	2 x per year
Lab Work	As needed in addition to the therapies
Assistance with feeding	Daily
Stretching and assistance with exercises	Daily due to muscle spasticity
Dressing and toileting assistance	Daily
Endoscopy and Colonoscopy	Annually and as needed
Mobility assistance	Daily

DMA 6(A) #16, Treatment Plan

Previous Hospitalizations (and Procedures)

Date	**Inpatient Admission or Outpatient**	**Diagnosis**	**Diagnostic procedures**
August 1-10, 2011	Inpatient Admission	Respiratory Infection Croup	
January 2015-Sept 2021	Outpatient	Muscle Spasticity	Multiple sessions of Botox under sedation
Oct 2018	Outpatient	Spasticity	Tibia Osteotomy & Muscle Lengthening Surgery
Nov 1-10, 2021	Inpatient Admission	Crohn's Disease	

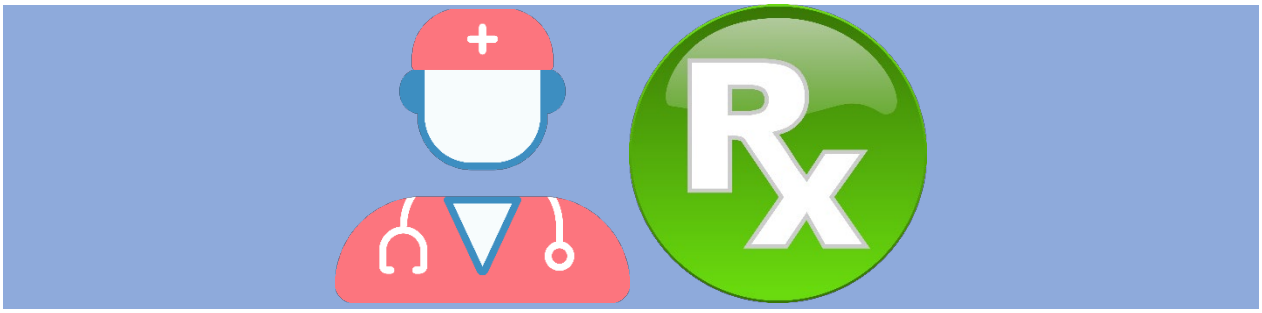
Rehabilitative services

Physical Therapy School	2 x Week @ 30 minutes per session
*Private Physical Therapy	1 x Week @ 60 minutes per session
Speech Therapy School	2 x Week @ 30 minutes per session
*Private Speech Therapy	2 x Week @ 60 minutes per session
Occupational Therapy School	2 x Week @ 30 minutes per session
*Private Occupational Therapy	2 x Week @ 60 minutes per session
*Private Behavior Therapy	3 x Week @ 120 minutes per session

***Your child's name** isn't currently receiving these ordered and medically necessary therapies due to cost

Dr. 's Signature

Dr.'s Typed Name



ORDER OF MEDICAL NECESSITY FOR SERVICES

Date: January 10, 2022

Re: **Your Child's Name**

DOB: 10/21/2010

Medicaid Number: New Application

The following services are physician ordered and medically necessary for my patient, **your child's name.**

Physical Therapy School	2 x week @ 30 minutes per session
*Private Physical Therapy	2 x week @ 60 minutes per session
Speech Therapy School	2 x week @ 30 minutes per session
*Private Speech Therapy	2 x week @ 60 minutes per session
Occupational Therapy School	2 x week @ 30 minutes per session
*Private Occupational Therapy	2 x week @ 30 minutes per session
*Private Behavior Therapy	3 x week @ 120 minutes per session

***Your child's name** isn't currently receiving these ordered and medically necessary therapies due to cost

Your child's name has multiple medical needs and requires daily active treatment. He requires assistance with most activities of daily living including feeding, dressing, toileting and mobility assistance. He requires daily medication administration. Daily he requires stretching and assistance with prescribed exercises due to muscle spasticity.

Your child's name has the following diagnoses: _____, _____, _____, _____, _____. His last psychological evaluation on 10/4/2021 by Dr. XXXXXXX, showed a Full Scale IQ on the PTONI of 45, his GARS-3 is a 127, and on the Vineland-3 Adaptive Behavior Composite his score is 55. He meets the eligibility requirements for the TEFRA/Katie Beckett Deeming Waiver.

Physician's Signature

_____

Physician's Typed Name

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: Your Child's Name Medicaid #: If your child doesn't have medicaid put N/A

Diagnosis: F84.0 Autism, Cerbral Palsy, Down Syndorme *Please see attached for additional diagnoses

Prognosis: Patient has signifcant developmental disabilities, but with therapy and treatment he will be able to make progress.

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	$ 150.00
• Durable medical equipment	50.00
• Drugs	90.00
• Therapy(s)	2000.00
• Skilled Nursing Services	
• Other(s) Behavior Supports	500.00
TOTAL	$ 2790.00

Note:
From 1/2022 Manual Level of Care
Monthly Amount (average Medicaid rates)
*Skilled Nursing Facility $6,344.46 (31 days)
*ICF/ID $14,846.23 (31 days)

Since this application is for ICF/ID LOC, The total cost should not exceed $14,846.23 per month for Medicaid to consider it cost effective.

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

X Yes _____ No

COMMENTS:

Child has private insurance that will cover therapies, prescription costs, hospitalizations and physicians services. Medicaid will only have to pay for Co-pays and deductibles. Child uses a Wheel Chair, assistive technology, orthotics all of which do not have a monthly cost, but some of these costs are covered by private insurance. Ins pays 80% of everything except doctors visits require a $50.00 copay. Maximum out of pocket for the individual is $5000.00 per year.

PHYSICIAN'S SIGNATURE Dr.'s Signature

DATE: 01/10/2022

DMA Form 704
Rev. 10-04

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)	Immigration Document ID# (If applicable)
Your Child's Name	Kennesaw, GA, USA	X			A-
					A-
					A-
					A-
					A-

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

Signature of John Doe _____ 01/10/2022 _____
SIGNATURE (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)	Immigration Document ID# (If applicable)
					A-
					A-

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

_____ _____
SIGNATURE (DATE)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) Program

Head Of Household: John Doe (Primary Ins. Holder)	Referral Source: John Doe (Person completing application)
Address: Your Address	Address: Your Address
City: Marietta State GA	City: Marietta State: GA
Zip: 30080 Tel. #John Doe's number	Zip: 30080 Telephone #: John Doe's number

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

Policy holder's name: John Doe
Policy number: 123456789
Group number: 34545454
Policy holder's SSN: 555-55-5555
Policy holder's date of birth: 11/13/1980
Insurance Co. name: Blue Cross Blue Shield
Insurance Co. address: 2345 Best Road
City/State/Zip: Marietta, GA 30080
Telephone #: Insurance Phone number

2. What is the annual Maximum Out of Pocket Expense for the: Individual? 2500.00 **Family?** 10,000.00

3. Is the annual deductible included in the out of pocket expense? YES X NO

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

5. Is this policy an HMO or PPO? YES X NO

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

Employer name: Best Employer
Employer telephone: Human Recources #
Employer address: 2345 Best Road
City/State/Zip: Marietta, GA 30062

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. Your Child's Name	555-55-5555	10 /21/ 2010	N/A	Child	M
2.		/ /			
3.		/ /			
4.		/ /			
5.		/ /			

8. Are any of these persons pregnant? Yes _____ NO X **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).

YES **Name** Your Child's Name **Condition** F84.0 Autism, Cerebral Palsy, Down Syndrome & See Attachment for Additional **NO** _____

10. If known, how much are the premiums for this policy? $ 400.00

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** X 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 X **NO** _____

14. Was applicant or any dependent injured at work or in an accident in the last 12 months? YES ____ **NO** X If yes,
Attorney Name, if applicable: _____ **Ins. Company, if applicable:** _____

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

John Doe's Signature
Signature of applicant

01/10/2022
Date

DMA-124 Rev 12/13

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

CASE NAME: Your Child's Name

CASE NO: If you don't have one then put N/A

ADDRESS: Your Address

City, State Zip Code

SSN: Your Child's Social Security Number

PHONE NO: Your Phone number

TYPE OF CASE: ☒ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
(Check all that apply) ☒ HIPP REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION: ____/____/____

HIPP APPLICATION IS MARKED IF YOU HAVE AN EMPLOYER SPONSORED HEALTH INSURANCE

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

* These are answered on the basis that the parent has a health ins policy that the child is covered under.

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) Policy Holder	Spouse	Child	Step-child	Other	Date Of Birth
Doe	John	B	N/A		X					11/13/1980
Doe	Jane	C	N/A			X				10/21/1983
Doe	Your Child's Name		N/A	555-55-5555			X			Your Child's Birth-date

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 Your Child's Name Condition F84.0 Autism, & See Attachment

Blue Cross Blue Shield (888) 888-8888
(Insurance Company Name) (Telephone Number)

Normally a PO Box address or a web address | Marietta | GA | 30080
(Address) (City) (State) (Zip)

John Doe | John's SS # | 999999 | 11/13/1980
(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

10/15/2021 NONE
(Policy Effective Date) (Policy Termination Date)

Best Employer 888-888-8888
(Employer Name) (Telephone Number)

2345 Best Road | Marietta | GA | 30062
(Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)

(01) – HOSPITAL INPT.
(07) – DRUG/STND
(08) – MAJOR MED.
(09) – DENTAL
(10) – VISION
OTHER_____
15 – LTC/NH
16 – HMO/DRUG
17 – MED. SUPP A
18 – MED. SUPP B
22 – HMO/STND

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 John or Jane Doe's Signature Date 01/10/2022
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 John Doe's Signature Date 01/10/2022
Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY_____

Case Worker Name:_____ Phone No:_____ County_____

DMA-285-REV. (01/06)

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Effective Date: August 15, 2013

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

If you have any questions about this notice, please contact:
Georgia Department of Human Services
HIPAA Privacy Officer
HIPAA1@dhr.state.ga.us
(404) 657-9761 phone
(404) 657-1123 fax

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

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

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

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

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

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

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the

treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

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

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

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

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

SPECIAL SITUATIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

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

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

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

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

YOUR RIGHTS:

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

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the above referenced HIPAA Privacy Officer. DHS has up to 30 days to make your Protected Health Information available to you

and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

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

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

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

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

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

Right to Request Confidential Communications. You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the above-referenced HIPAA

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

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

CHANGES TO THIS NOTICE:

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

COMPLAINTS:

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

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

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

Jane Doe's Signature _____ Date _____

Signature Date

Jane Doe's Name _____

Print Name

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Effective Date: August 15, 2013

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If you have any questions about this notice, please contact:
Georgia Department of Human Services
HIPAA Privacy Officer
HIPAA1@dhr.state.ga.us
(404) 657-9761 phone
(404) 657-1123 fax

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

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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.

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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:

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and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

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

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.

John Doe's Signature

Signature

01/10/2022

Date

John Doe's Name

Print Name

BRIAN P. KEMP
GOVERNOR

TOM C. RAWLINGS
DIRECTOR

VOTER REGISTRATION

Dear Client:

Enclosed is the **Georgia Voter Registration Form** you requested.

If you are not registered to vote where you live now, you may apply to register to vote by completing the voter registration form. You may also register online through the Secretary of State's website at: http://sos.ga.gov/.

If you decide to complete a voter registration application form, it should be mailed to the Secretary of State (no postage necessary) or you can bring the completed form to your local DFCS office and we will forward it to the Secretary of State for you.

Do not place correspondence for DFCS in the addressed pre-paid envelope.

If you would like help in filling out the voter registration application form, please contact your local DFCS office. You may also request assistance at your county elections office.

Your decision to apply to register to vote will not affect the amount of assistance that you will be provided by this agency.

This is not a required form for the Katie Beckett Application. You may fill it out and send it in if it is applicable to your situation.

DHS Division of Family & Children Services

VOTER REGISTRATION DECLARATION STATEMENT

Name: _____ Date: _____
(Last) (First)

Important Notice: Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

_____ Yes

_____ No

IF YOU DO NOT CHECK ANY BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

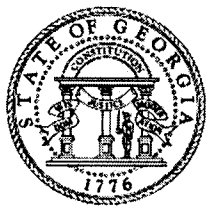
If you believe that someone has interfered with your right to register or decline to register to vote or your right in privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the Secretary of State at: 2 Martin Luther King Jr. Dr. Suite 802 West Tower, Atlanta, GA 30334 or by calling 404-656-2871.

FOR OFFICE USE ONLY

_____ Check here if client took blank application home to complete.

Please include any other explanatory information below:

This is not a required form for the Katie Beckett Application. You may fill it out and send it in if it is applicable to your situation.



DHS Division of Family & Children Services

VOTER REGISTRATION DECLARATION STATEMENT

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Please include any other explanatory information below: