Enclosed is a packet of forms to be completed for an application or review for the Katie Beckett Medicaid Class of Assistance. Please read all the information contained herein and complete the forms EXACTLY as outlined. Should you have problems or questions, contact the Medicaid Eligibility Specialist (MES) at the telephone number provided above. The packet of forms should include the following as checked below:

- Medicaid Application, Form 700, (answer questions as if your child was completing)
- Verification Checklist, Form 981
- Pediatric DMA-6(A), Physician’s Recommendation for Pediatric Care
- Pediatric DMA-6(A) Instructions
- TEFRA/Katie Beckett Medical Necessity level of care statement, DMA Form 706
- TEFRA/Katie Beckett Medical Necessity level of care statement, Instructions
- TEFRA/Katie Beckett Cost-Effectiveness Form, DMA Form 704
- Other Therapy Notes
  - F218 Enclosed
  - F285 Enclosed

Please return the completed information to DFCS by ___________________.
If you need an extension, please contact case worker by the above due date.
Have you or anyone in your household been diagnosed with breast or cervical cancer? NO □ YES □

Does anyone in your household have health insurance? NO □ YES □

If yes, list insurance company and policy number:

Please make a list of your Long Term Care Plan.

Date:

Person(s) living at the household with whom you DON'T want Medicaid. If you don't want Medicaid, let your provider know who you DON'T want Medicaid.

Residence address (if different from mailing address):

Mailbox (if applicable):

Please note: A face to face interview is not required for Medicaid applications. If you cannot understand or complete this application, PLEASE APPLY A FACE TO FACE INTERVIEW IS NOT REQUIRED FOR MEDICAID APPLICATION. PLEASE APPLY A FACE TO FACE INTERVIEW IS NOT REQUIRED FOR MEDICAID APPLICATION. Please answer all questions as completely and accurately as possible. If you cannot understand or complete this application, apply to Medicaid.

Medical Assistance Program - Medicaid

Application

Are you in foster care or on TANF?

Yes □ No □

Are you in foster care on your 18th birthday? Yes □ No □

If you are an eligible individual, check the block(s) that apply.


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

Please note: A face to face interview is not required for Medicaid applications. If you cannot understand or complete this application, apply to Medicaid.

MEDICAID APPLICATION
### INCOME, RESOURCES 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.**

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

**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?**

<table>
<thead>
<tr>
<th>Name of Parent who works</th>
<th>Name of child or adult cared for</th>
<th>Name of care provider</th>
<th>Amount of Payment</th>
<th>How Often? (weekly, 2-weeks, monthly, etc)</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Absent Parent's Name (Mother/Father)</th>
<th>Do they have Medical Coverage on the Child?</th>
<th>If Yes to Medical Coverage, please list name of insurance company &amp; group number</th>
</tr>
</thead>
</table>

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: ____________________________

Form 94 (11/10)
DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

I understand that the Ga. Division of Family and Children Services may require verification from the United States Department of Homeland Security 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Place of Birth (city, state, country)</th>
<th>U.S. Citizen</th>
<th>Lawfully Admitted Immigrant</th>
<th>Date Naturalized or Admitted into U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Check whichever applies)</td>
<td>(If applicable)</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

______________________________
(SIGNATURE (PARENT/GUARDIAN))

DATE

### ADULT(S) SEEKING BENEFITS

<table>
<thead>
<tr>
<th>Name</th>
<th>Place of Birth (city, state, country)</th>
<th>U.S. Citizen</th>
<th>Lawfully Admitted Immigrant</th>
<th>Date Naturalized or Admitted into U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Check whichever applies)</td>
<td>(If applicable)</td>
</tr>
<tr>
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</tr>
</tbody>
</table>

I, __________________________ certify under penalty of perjury, that the information written and checked above is true.

______________________________
(SIGNATURE (PARENT/GUARDIAN))

DATE

______________________________
(SIGNATURE (PARENT/GUARDIAN))

DATE

Form 94 (11/10)
## Section A - Identifying Information

1. Applicant's Name/Address:
   - Name: 
   - Address: 
   - DFCS County: 

2. Medicaid Number: 
3. Social Security Number: 
4. Sex   Age   4A. Birthdate

5. Primary Care Physician: 
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, whenever 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) ___________________________  2) ___________________________  3) ___________________________
   (Add attachment for additional diagnoses)

14. Medications
<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Route</th>
<th>Frequency</th>
<th>Type</th>
<th>Frequency</th>
</tr>
</thead>
</table>

15. Diagnostic and Treatment Procedures

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:  
   - 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  
   - could not be managed by provision of  
   - Community Care  
   - 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 #: ___________________________
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Regular</td>
<td>Age Dependent</td>
<td>Monitoring</td>
<td>Prosthesis</td>
<td>Agitated</td>
</tr>
<tr>
<td>Diabetic Shots</td>
<td>Incontinence</td>
<td>CPAP/Bi-PAP</td>
<td>Splints</td>
<td>Cooperative</td>
</tr>
<tr>
<td>Formula-Special</td>
<td>Incontinent - Age &gt; 3 years</td>
<td>CP Monitor</td>
<td>Unable to ambulate &gt; 16 months old</td>
<td>Alert</td>
</tr>
<tr>
<td>Tube feeding</td>
<td>Colostomy</td>
<td>Pulse Ox</td>
<td>Wheel chair</td>
<td>Developmental Delay</td>
</tr>
<tr>
<td>N/G-tube/G-tube</td>
<td>Continent</td>
<td>Vital signs &gt; 2/days</td>
<td>Normal</td>
<td>Mental Retardation</td>
</tr>
<tr>
<td>Slow Feeder</td>
<td>Other</td>
<td>Therapy</td>
<td></td>
<td>Behavioral Problems</td>
</tr>
<tr>
<td>FTT or Premature</td>
<td></td>
<td>Oxygen</td>
<td></td>
<td>(please describe, if checked)</td>
</tr>
<tr>
<td>Hyperal</td>
<td></td>
<td>Home Vent</td>
<td></td>
<td>Suicidal</td>
</tr>
<tr>
<td>IV Use</td>
<td></td>
<td>Trach</td>
<td></td>
<td>Hostile</td>
</tr>
<tr>
<td>Medications/GT</td>
<td></td>
<td>Nebulizer Tx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meds</td>
<td></td>
<td>Suctioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest - Physical Tx</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Room Air</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Care</td>
<td>Dialysis in home</td>
<td>Level 1 (5 or &gt; surgeries)</td>
<td>Day care Services</td>
<td>Deaf</td>
</tr>
<tr>
<td>Sterile Dressings</td>
<td>Ostomy</td>
<td>Level II (&lt; 5 surgeries)</td>
<td>High Tech - 4 or more times per week</td>
<td>Blind</td>
</tr>
<tr>
<td>Decubiti</td>
<td>Incontinent - Age &gt; 3 years</td>
<td>None</td>
<td>Low Tech - 3 or less times per week or MD visits &gt; 4 per month</td>
<td>Seizures</td>
</tr>
<tr>
<td>Bedridden</td>
<td>Catheterization</td>
<td></td>
<td></td>
<td>Neurological Deficits</td>
</tr>
<tr>
<td>Eczema-severe</td>
<td>Continent</td>
<td></td>
<td></td>
<td>Paralysis</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
<td>Normal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>39. Other Therapy Visits</th>
<th>40. Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five days per week</td>
<td></td>
</tr>
<tr>
<td>Less than 5 days per week</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>41. Pre-Admission Certification Number:</th>
<th>42. Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>43. Print Name of MD or RN:</th>
<th>Signature of MD or RN:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DO NOT WRITE BELOW THIS LINE**

<table>
<thead>
<tr>
<th>44. Continued Stay Review Date:</th>
<th>Admission Date:</th>
<th>Approved for Days or Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>46A. State Authority MH &amp; MR Screening</th>
<th>46B. This is not a re-admission for OBRA purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I/II</td>
<td>Date</td>
</tr>
<tr>
<td>Restricted Auth. Code</td>
<td>Date</td>
</tr>
<tr>
<td>Restricted Auth. Code</td>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>47. Hospitalization Precertification</th>
<th>48. Level of Care Recommended by Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
<td>Hospital</td>
</tr>
<tr>
<td>Not Met</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td></td>
<td>ICF/MR Facility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>49. Approval Period</th>
<th>50. Signature (Contractor)</th>
<th>51. Date</th>
<th>52. Attachments (Contractor)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DMA-6A (11/2011)</th>
</tr>
</thead>
</table>

Page 2 of 2
PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

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

This section provides detailed instructions for completion of the *Form DMA-6 (A)*. Before payment can be made, a *Form DMA-6 (A)* must be completed by the Primary Care Physician (PCP) and the parent or legal representative and signed by the PCP. The Form DMA-6 (A) is considered valid only if it is signed by the Primary Care Physician and dated.

---

Section A - Identifying Information

It is the responsibility of the responsible party to see that Section A of the form is completed with the applicant's name and address.

**Item 1:** Applicant's Name and Address
Enter the complete name and address of the applicant including the city and zip code.

The KB Medicaid Specialist will complete the mailing address and county of the originating application.

**Item 2:** Medicaid Number
Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by the KB Team staff or making application for services, the number will be the 9-digit SUCCESS number plus a “P”, e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an “S”, e.g., 123456789S.

The entire number must be placed on the form correctly. In exceptional instances, it may be necessary to contact the KB Medicaid Specialist for the Medicaid number.

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

**Item 4&4A: Sex, Age and Date of birth**
Enter the applicant'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 applicant’s parent or the legal representative.

Item 7: **Does the parent or legal representative think the applicant should be institutionalized?**  
Please check the appropriate box.

Item 8: **Does the child attend school?**  
Please check the appropriate box if the member attends school.

Item 9: **Date of Medicaid Application**  
Enter the date the family made application for Medicaid services.

**Fields below Item 9:**  
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, please 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).

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

Section B - Physician’s Examination Report and Recommendation

Item 12: **History (attach additional sheet(s) if needed)**  
Describe the applicant’s medical history (Hospital records may be attached).

Item 13: **Diagnosis (Add attachment(s) for additional diagnoses)**  
Describe the primary, secondary, and any third diagnoses relevant to the applicant’s condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor’s staff will complete these boxes.

Item 14: **Medications (Add attachment(s) for additional medication(s)**  
The name of all medications the applicant is to receive should be listed. Name of drugs with dosages, routes, and frequencies of administration are to be included.
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/habilitation, and other health care services the applicant has received or currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization
List any dates the applicant may be hospitalized in the near future for services.

Item 18: Level of Care Recommended
Recommendation regarding the level of care considered necessary. Enter a check in the correct box for hospital, nursing facility, or an intermediate care facility for the mentally retarded.

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

Item 20: Patient Transferred from (Check one)
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Enter a check in the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant’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 applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable.

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)

Licensed personnel involved in the care of the applicant should complete Section C of this form.

Item 29:  Nutrition  
Check the appropriate box(es) regarding the nutritional needs of the applicant.

Item 30:  Bowel  
Check the appropriate box(es) to indicate the bowel and bladder habits of the applicant.

Item 31:  Cardiopulmonary Status  
Check the appropriate box(es) to indicate the cardiopulmonary status of the applicant.

Item 32:  Mobility  
Check the appropriate box(es) to indicate the mobility of the applicant.

Item 33:  Behavioral Status  
Check all appropriate boxes (es) to indicate the applicant’s mental and behavioral status.

Item 34:  Integument System  
Check the appropriate box(es) to indicate the integument system of the applicant.
Item 35: Urogenital
Check the appropriate box(es) for the urogenital functioning of the applicant.

Item 36: Surgery
Check the appropriate box regarding the number of surgeries the applicant has had to your knowledge or obtain this information from the parent or other legal representative.

Item 37: Therapy/Visits
Check the appropriate box to indicate the amount of therapy visits the applicant receives.

Item 38: Neurological Status
Check the appropriate box(es) regarding the neurological status of the applicant.

Item 39: Other Therapy Visits
If applicable, indicate the number of treatment or therapy sessions per week the applicant receives or needs.

Item 40: Remarks
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form or any additional comments.

Item 41: Pre-admission Certification Number
Indicate the pre-admission certification number (if applicable).

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

Item 43: Print Name of MD or RN
The individual completing Section C should print their name and sign the DMA-6 (A).

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:

<table>
<thead>
<tr>
<th>Cardiovascular:</th>
<th>None</th>
<th>Description of Skilled Nursing Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integumentary:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urogenital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel:</td>
<td></td>
<td></td>
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<tr>
<td>Endocrine:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immune:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skeletal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 facility 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.

DMA □ 706
Rev. 08/11
TEFRA/KATIE BECKETT MEDICAL NECESSITY/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

**Member (Applicant) Information**
1. Enter the Member’s Name, DOB and SS#

**Diagnosis**
1. Enter the Member’s primary, secondary, and any third diagnoses relevant to the member’s condition

**Level of Care**
1. Enter a check in the correct box for the recommended level of care.

**Medical History**
1. Provide narrative of member’s medical history or attach documents i.e., hospital discharge summary, etc.

**Current Needs**
1. Check member’s current needs and provide description of skilled nursing needs.

**Therapy**
1. Include frequency per week of therapies and attach current notes.

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

**School**
1. Enter a check for member’s appropriate school attendance and IFSP or IEP plan.

**Signature**
1. The primary care physician or physician of record must sign and date.
2. 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.
CITIZENSHIP/IDENTITY VERIFICATION  AU NAME: __________________________

CHECKLIST

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 (KICX)(Issued by DHS to identify U.S. citizens 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:
  o Extract of hospital record on hospital letterhead established at the time of person’s birth
  o Life, health or other insurance record
  o An amended US public birth record
  o Medical clinic (not Health Dept.), doctor or hospital record indicating a US place of birth
  o 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

Form 218 Rev. 11/09
agency. If you have questions, please contact your local county Medicaid case manager.
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
deach 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 employer in the spaces provided.

Rev. 01/07
16. List the names of the household members who are Medicaid A/Rs covered under the insurance policy. Enter their relationship to the A/R given as the “Case Name” at the top of the form. If it’s the same write “Self”. Provide the date of birth. Enter the SUCCESS ID #. Enter the SSN of the individual.

17. If possible, have the A/R or PR sign the document in the two spaces provided.

18. The worker should LEGIBLY PRINT his/her name, DIRECT phone number and DFCS county.

19. See Section 2230 for mailing/faxing instructions.

**NOTE:** PCG, the entity charged with handling DMA-285, has a 30 day standard of promptness. If it is necessary to have an immediate correction made concerning a TPR, fax the information to PCG rather than mailing. At times MHN may show insurance coverage that the MES is not aware of. Always double check with the A/R before assuming that the insurance shown is not valid. However, a pharmacy should never deny a member their prescriptions because of TPR issues. They have override codes to enter to make the prescription claim be accepted.
GEORGIA DEPARTMENT OF COMMUNITY HEALTH - THIRD PARTY LIABILITY HEALTH INSURANCE INFORMATION QUESTIONNAIRE

CASE NAME: ____________________________ CASE NO: ____________________________
ADDRESS: ____________________________________________________________
SSN: __ ____________________________ PHONE NO: ____________________________

TYPE OF CASE: ☐ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
☐ 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

Is policyholder an Absent Parent? ☐ 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

<table>
<thead>
<tr>
<th>Names of Covered Individuals in Household</th>
<th>Medicaid ID#</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last) - (First) - (MI)</td>
<td>Policy Holder - Spouse - Child - Step-Child - Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Policy Holder (check one)</th>
<th>Date Of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder - Spouse - Child - Step-Child - Other</td>
<td></td>
</tr>
</tbody>
</table>

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 ____________________________

<table>
<thead>
<tr>
<th>(Insurance Company Name)</th>
<th>(Telephone Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Address)</td>
<td>(City)</td>
</tr>
<tr>
<td>(State)</td>
<td>(Zip)</td>
</tr>
<tr>
<td>(Policyholder Name)</td>
<td>(Policyholder SSN)</td>
</tr>
<tr>
<td>(Policy Number)</td>
<td>(Policyholder DOB)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Policy Effective Date)</th>
<th>(Policy Termination Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Employer Name)</td>
<td>(Telephone Number)</td>
</tr>
<tr>
<td>(Employer Address)</td>
<td>(City)</td>
</tr>
</tbody>
</table>

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

EFFECTIVE DATE OF MEDICAID ELIGIBILITY ____________________________

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INSTRUCTIONS FOR COMPLETING
GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE
FORM DMA-285

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Rev. 01/07
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