Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

(QMB - payment of premiums, coinsurance, and deductibles;

SLMB - payment of Part B premium; **and QI-1** - payment of Part B premium)

INSTRUCT	ΓΙΟNS:												
2. Sign and m	-	on to:			-		accura	•	~ ~	litional pages if FCS	f neede	d.	
	county of resid		CS										
				ATT	 								
		ialist will	revie	ew this ap	plica	tion	. If it ap	pear	rs that you ma	ay be eligible for	r full M	edicai	d
PERSONAI	L INFORM	[ATIO]	N: Y	ou may	y hav	ve s	someo	ne l	nelp you co	omplete this a	applic	ation	•
Applicant's N	ame (Last, Fi	rst, Mid	dle I	nitial)					sh to name a the informa	a person to act of the trion below:	on you	r beha	ılf,
Mailing Addr	ess						_			iddle Initial)			
Street Address	S						Maili	ng A	Address				
City		State		Zip			City			State		Zip	
Do you own/a	re you purch	asing ho	ne?	\square Y		1							
Phone E-Mail Addre		Count	y				Phon		Address				
Nursing Facil		ble)							ship to Indiv	idual			
_													
COMPLET	E THIS IN	FORM				_					. 1		
Name (Self):			Birt	thdate	Sex		Race		S. Citizen es or No)	Social Securi	ity	Mari Statu	
Maiden/other	name(s):							(1)	c s of 110)	Transcr		State	•0
Name (Spouse	e):												
Maiden/other	name(s):												
Are you applyi	ng for your s	pouse, to	o?	□ Yes		No)						
Are you blind o	or disabled?	□ Yes		No - Is y	our s	pou	ise blin	d or	disabled? □	Yes □ No			
LIVING AR	RRANGEM	IENT:	Che	ck the b	ox(es)	that be	est (describes y	our current s	situatio	on.	
Living In	Nursing	Anothe		Hospice			spital		Katie	Community	Assis	ted	Other/
Own Home	Facility	Home				<u> </u>			Beckett	Care	Livin	g	Renting
	Date Admitted:					Da Ad	ite Imitted:			Date Admitted:			

HEALTH INSU	JRANCE:											
Do you have M	ledicare?	Тур	pe of C	overag	ge	Effecti	ve Date			you ever		
	No		Part A	. 🗆 F	Part B				receiv	ved SSI?		
Are you enrolled in a Medicare			nospital)		doctor)	3.6.11	NT			\square Yes \square No		
HMO or Medicare			Part D			Medica	are Nur			when did it		
	No		(RX)						end?_			
Does your spou	ise have		pe of C	_		Effecti	ve Date	e:	•	our spouse		
Medicare? □ Yes □ No			Part A	. 🗆 F	Part B					r received SSI?		
			Don't D			Medicare Number		nhari	$. \Box \mathbf{Yes} \Box \mathbf{No}$			
			Part I)		Wiedica	ale mui	niber.		when did it		
									end?_			
Do you have oth Does your spous If you answered	se have other h	ealth ii			□ Yo □ Yo	es 🗆	No No the foll	owing i	nform	ation:		
,	Health Insura			_	of Cov			Effec		Policy		
	Company Nat	me,		(Hos	pital, M	ledicare		Date		Number		
	Address, and	Teleph	none			Drugs,	Major					
	Number			Medi	cal,)							
Self												
Spouse												
Attach copies (1	front and hacl	z) of N		re and	lingurg	nce car	ds if a	nnlicah	le			
REAL PROPER If yes, please conhome in which	TY: Do you o	wn all	or part	of any	y real es	state in v	which y Do no	ou do n	ot live	se or mobile		
Address								Value	F	Amount Owed		
Do you or your s	spouse own a c	ar, tru	ck, boa	ıt, cam	per, uti	lity trail	er, recr	eational	l vehic	ele, etc.?		
☐ Yes ☐ No ☐ additional pages	• •	omple	te the f	ollowi	ng info	rmation	about 6	each vel	nicle.	Attach		
Type		Year	Make	 	Mode	<u> </u>	Value	<u> </u>	Amo	ount Owed		

RESOURCES:							•	_		•		
someone else. I		any	accoi	ants or pr	operties	on wh	nch y	our nan	ne(s) ap	pear. A	Attac	ch additional
pages if necessar Do you or your	-	hav	e anv	of the fo	allowing	resou	rces?	1				
Checking acco	-	\	•	□ No	U			epaid bu	rial iter	n □	Yes	□ No
Savings accoun		_ \		□ No		-	-	-			Yes	
Government be		☐ Yes☐ No☐ Stocks and bonds									Yes	□ No
Trust funds	311 G 5			□ No		IRA, CD, promissory note, etc.)					□ No	
Have you or yo	nir snai					•		•			Yes Yes	
If you answered												
Type of Resource Acc				ount/ Pol		Value Name of Bank, Ir Etc.				_		
Do you or your If yes, please co	-				-		sh ad	ditional	nagasi	□ Yes		□ No
Policy Owner	Impiete			e Compa		Polic			pages 1	Face	saiy.	Cash Value
Toney Owner		11150	ur arre		.iiy	Tone	y I (u.			Value		Cusii varae
INCOME ANI receives. List the premiums are to Social Security	ne incon	ne ai	moun	t before	deductional pages	ns (su	ch as	taxes, in	nsuranc include	e, or Mes, but i	ledic is no	eare
Railroad Retires	ment Be	enefi	ts	Ve	terans' B	Benefit	S		_		-	Payments
Pensions/ Retire			its		ntal Inco		id to	You		-		ineral Rights
Name of Person Who Receives Income		Source of Income Name of Employ				ount How Off Received (weekly, monthly,		ved?		im Number applicable)		
Are you a vetera	an? 🗆 Y	Yes	□ N	o Is you	r spouse	a vete	eran?	\Box Y	es 🗆	No	I	
Where did you	and spot	use v	work	in the pa	st?							
Do you or your	spouse	have	any	unpaid n	nedical b	ills?	[⊐ Yes □	□ No			

PRIVACY STATEMENT:

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

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

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

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

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

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

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

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

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

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

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

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

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services Division of Family and Children Services

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

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

	CHILDREN SEEKIN	G BENEFI	TS		
		U.S. Citizen	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S	
Name	Place of Birth(city,state,country)	(check which	hever applies)	(If applicable)	
	attest to the identity of altry of perjury, that the information				
SIGNATURE (P.	ARENT/GUARDIAN)	(<u>[</u>	PATE)		
	ADULT(S) SEEKING	G BENEFI	TS		
Name	Place of Birth(city,state,country)	U.S. Lawfully Citizen Admitted Immigrant (check whichever applies)		Date Naturalized or Admitted into U (If applicable)	
1 (81110		(enteri wine		(ii uppiicusio)	
(PRINT NAM	certify under penal ecked above is true.	ty of perjury,	that the inform	nation	
SIGNATURE (I	PARENT/GUARDIAN)		DATE)		
SIGNATURE (I	PARENT/GUARDIAN)		DATE)		