

# Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

**INSTRUCTIONS:**

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

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

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

**COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.**

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

Are you applying for your spouse, too?  Yes  No

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

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

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





**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.

<b>Signature of Applicant or Representative:</b>	<b>Date:</b>
<b>Signature of Applicant’s Spouse or Representative:</b>	<b>Date:</b>

## 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	Date Naturalized or Admitted into U.S. (If applicable)

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

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)

### ADULT(S) SEEKING BENEFITS

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

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

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)