DCH/KATIE BECKETT MEDICAID APPLICATION INFORMATION:

PLEASE MAIL COMPLETED APPLICATION BACK TO EITHER ADDRESSES BELOW:

DEPARTMENT OF COMMUNITY HEALTH
KATIE BECKETT UNIT
P.O. BOX 172
NORCROSS, GA 30091

OR

2211 BEAVER RUIN ROAD
SUITE # 150
NORCROSS, GA 30071

IF YOU HAVE ANY QUESTIONS, FEEL FREE TO CONTACT US AT:
PHONE: 678-248-7449
FAX: 678-248-7459

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?_____

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:	
Mailing Address:			City:	State:	Zip Code:
Residence Address (if different from Mailing Address):			Phone Number(s):	E-mail Address:	

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)	

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).

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

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

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			
Current Employer:			
Wages/Earnings			
Current Employer:			
Social Security Income/SSI			
Worker's Compensation			
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**

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): _____ 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 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-
					A-
					A-
					A-

I, _____ 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 (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)

CITIZENSHIP/IDENTITY VERIFICATION CHECKLIST

AU NAME: _____

AU NUMBER: _____

CITIZENSHIP/IDENTITY MUST BE VERIFIED FOR ALL MEDICAID APPLICATIONS/RENEWALS

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 the DFCS Customer Service line or your local county DFCS office for clarification.

Please provide one of the following, and return using the contact information on the verification checklist.

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 "KIC" (Issued by DHS to identify U.S. citizen 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 :
    - Extract of hospital record on hospital letterhead established at the time of person's birth
    - Life, health or other insurance record
    - An amended US public birth record
    - Medical clinic(not Health Dept.), doctor or hospital record indicating a US place of birth
    - Institutional admission papers from nursing home, skilled nursing care facility or other institution

If you do not have any of the above, please contact the DFCS Customer Service line or your local county DFCS office 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. The Form 3231 immunization record from the Department of Public Health (DPH) is acceptable if an immunization date on the form was documented before the individual's 16th birthday.
- Affidavit signed under penalty of perjury by a parent/guardian. **(Contact the DFCS Customer Service line or your local county DFCS office.)**
- A signed Declaration of Citizenship form that includes the date and place of birth of the child. **(Contact the DFCS Customer Service line or your local county DFCS.)**
- All documents that verify citizenship/identity must be either ORIGINALS or copies CERTIFIED by issuing agency.

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 death 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 employment in the spaces provided.

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
(Check all that apply) ☐ 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

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)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	

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_____

_____(_____)_____
(Insurance Company Name) (Telephone Number)

_____
(Address) (City) (State) (Zip)

_____
(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

_____
(Policy Effective Date) (Policy Termination Date)

_____
(Employer Name) (Telephone Number)

_____
(Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)

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

OTHER_____

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_____

Case Worker Name:_____ Phone No:_____County_____

DMA-285-REV. (01/06)

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:	Referral Source:
Address:	Address:
City: State	City: State:
Zip: Tel. #	Zip: Telephone #:

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

Policy holder's name:_____ Insurance Co. name: _____
Policy number:_____ Insurance Co. address:_____
Group number: _____ City/State/Zip:_____
Policy holder's SSN:_____ Telephone #: _____
Policy holder's date of birth:_____

2. What is the annual Maximum Out of Pocket Expense for the: Individual?_____ Family?_____

3. Is the annual deductible included in the out of pocket expense? YES___ NO_____

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

5. Is this policy an HMO or PPO? YES___ NO_____

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

Employer name: _____ Employer address:_____
Employer telephone:_____ City/State/Zip:_____

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.		/ /			
2.		/ /			
3.		/ /			
4.		/ /			
5.		/ /			

8. Are any of these persons pregnant? Yes_____ NO_____ 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).

Name Condition

YES _____ **NO** _____

_____

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

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**____ 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_____ NO_____

14. Was applicant or any dependent injured at work or in an accident in the last 12 months? YES___ NO____ If yes,
Attorney Name, if applicable: **Ins. Company, if applicable:**

_____ _____

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

_____ _____

Signature of applicant **Date**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS FOR COMPLETION OF APPLICATION FOR THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM
DMA-124

Head of Household

Provide the name of the head of household and address and telephone number where he or she may be reached if additional information or data verification is required.

Referral Source

Provide the name and address of the person completing the application. A copy of the decision on the application will be returned to the referral source.

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

Please enter the complete name of the policyholder, the policyholder's social security number and date of birth. Also, please provide BOTH the insurance policy number, if applicable, and group number, if applicable, address and telephone number of the insurance company. The telephone number should be the number for the insurance company's customer service department. This information is usually available on the member's insurance card.

2. Is the policy referenced in #1 the primary policy?

Only primary policies are eligible for the HIPP Program. Secondary or supplement policies are not eligible.

3. Is there a secondary policy with another employer?

Does the Medicaid member have a secondary policy with another employer? Please check "Yes". If not, check "No".

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

Please provide the policyholder's employers name, address and telephone number. We will need to verify information with the employer and not the policyholder. Also, please provide the same information if the policy holder is self-employed. If this is a non-group policy, please attach a copy of the current billing statement for premium verification. Providing this information with the application will expedite the verification process.

5. List all Medicaid eligible persons covered under this policy.

List all persons living at this address who are **Medicaid eligible** and possibly eligible for coverage under this policy. Enter the full name, Social Security Number, date of birth, Medicaid identification number, relationship to the policy holder, and gender for each person. If there are more than five persons, include the additional information on the back of the application.

6. Are any of these persons pregnant?

If any person in #5 above is pregnant, check "Yes" and enter the expected delivery date. If none are pregnant, check "No".

7. Have any of the persons in #5 above been diagnosed with a medically expensive condition?

If any person in #5 above is currently diagnosed with a medically expensive condition, enter the individual's name and the diagnosis. If no medically expensive conditions exist, enter "No". Medical conditions include but are not limited to: Diabetes, Blood Disorder, Cancer, Intellectual Disabilities and/or Developmental Disabilities, Heart Condition, Asthma, Scoliosis or other Back Injury, Stroke, Seizure Disorder, Kidney/Liver Disorder, Alcohol/Drug Addiction, HIV Positive/AIDS.

8. If known, how much are the premiums for this policy? $_____

Please provide the per pay period premium amount for medical coverage.

9. **How often is the premium amount paid?**

Please select the frequency of deductions for the amount provided in #8.

10. **Complete the following information if COBRA benefits might be available**

If the policy holder is eligible for COBRA benefits, check "Yes" if COBRA forms have been received, and "No" if none were received. If "Yes", please enter the date the forms were received and last date of employment. Indications of COBRA coverage might be a recent job termination, recent layoff from a job, or a new job where the benefits do not cover a pre-existing condition. Please attach a copy of the COBRA enrollment packet to this application. This information is needed to determine if the HIPP Program can assist with the premium payments for the COBRA plan.

11. **Can we contact your employer and/or insurance carrier to verify this information?**

Check "Yes" if the employer and/or insurance company can be contacted for verification. If "No" is checked, the application will be denied for insufficient information to process the application.

12. **Has the applicant or any dependents been involved in an accident?**

Check "Yes" if the applicant or any of the dependents listed were involved or injured in an accident that required medical attention within the last 12 months. If an attorney or insurance company is involved, please obtain this information and note it on the application. If no accidents occurred, please check "NO"

13. **Sign and date this application.**

The applicant does not have to be the policy holder. However, the policyholder must sign and date the application upon completion. Please send the completed application to the following:

HMS
HIPP Unit
900 Circle 75 Parkway
Suite 650
Atlanta, GA 30339
Fax: 800-817-1769
Email: hippga@hms.com (attachments only – PDF preferred method)

Should you have any questions, you may contact the HIPP Unit directly at 678-564-1162, Option 1.

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

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

It is important that EVERY item on the DMA-6(A) is answered, even if it is answered as N/A (not applicable). Make sure that the physician or nurse who completes some of the sections is aware of this requirement. The form is only valid for 90 days from the date of the physician's signature. The form should be completed as follows:

Section A – Identifying Information

Section A of the form should be completed by the parent or the legal representative of the Katie Beckett child unless otherwise noted. All reference to "the applicant" means the child for whom Medicaid is being applied for.

Item 1: Applicant's Name/Address
Enter the complete name and address of the applicant including the city and ZIP code. For DFCS County enter the applicant's county of residence.

Item 2: Medicaid Number
To be completed by county staff.

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

Item 4: & 4A: Sex, Age and Birthdate
Enter the applicant's sex, age, and date of birth.

Item 5: Primary Care Physician
Enter the entire name of the applicant's Primary Care Physician.

Item 6: Applicant's Telephone Number
Enter the telephone number, including area code, of the applicant's parent or the legal representative.

Item 7: Does guardian think the applicant should be institutionalized?
If the Katie Beckett applicant were not eligible under this category of Medicaid, would s/he be appropriate for placement in a nursing facility or institution for the intellectually disabled. Check the appropriate box.

Item 8: Does the child attend school?
Check the appropriate box.

Item 9: Date of Medicaid Application
To be completed by county staff.

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, include 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) legibly.

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

Section B – Physician's Examination Report and Recommendation
This section must be completed in its entirety by the Katie Beckett child's Primary Care Physician. No item should be left blank unless indicated below.

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. Please note the ICD codes. Depending on the diagnosis, a psychological evaluation may be required. If you have an evaluation conducted within the past three years, include a copy with this packet.
Item 13A: ICD-10 Diagnosis Code (Add attachment(s) for additional diagnoses)
Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines.

Item 14: Medications – Add attachment(s) for additional medications(s))
The name of all medications the applicant is to receive must be listed. Include name of drugs with dosages, routes, and frequencies of administration.

Item 15: Diagnostic and Treatment Procedures
Include all diagnostic or treatment procedures and frequencies.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative and other health care services the applicant has received or is 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 anticipated dates of hospitalization for the applicant. Enter N/A if not applicable.

Item 18: Level of Care Recommended
Check the correct box for the recommended level of care; nursing facility or intermediate care facility for the intellectually disabled. If left blank or N/A is entered, it is assumed that the physician does not deem this applicant appropriate for institutional care.

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 for 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?
Check the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could be managed by provision of the Community Care of Home Health Care Services Programs. Check either/both box(es) corresponding to Community Care and/or Home Health Services if either/or 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 or an intermediate care facility for the intellectually disabled. **This must be an original signature; signature stamps are not acceptable.** If the physician does not deem this applicant appropriate for institutional care, enter N/A and sign.

Item 26: Date Signed by the Physician
Enter the date the physician signs the form.

Item 27: Physician's Licensure Number
Enter the attending or admitting physician's license number.

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 boxes only)

This section may be completed by the Katie Beckett child's Primary Care Physician or a registered nurse who is well aware of the child's condition.

Items 29—38: Check each appropriate box.

Item 39: Other Therapy Visits
If applicable, check the appropriate box for the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.

Item 40: Remarks
Enter additional remarks if needed or "None".

Item 41: Pre-admission Certification Number
Leave this item blank.

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

Item 43: Print Name of MD or RN/Signature of MD or RN
The individual completing Section C should print their name legibly and sign the DMA-6(A).
This must be an original signature; signature stamps are not acceptable.

Do Not Write Below This Line
Items 44 through 52 are completed by Contractor staff only.

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

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

Section A – Identifying Information

1. Applicant's Name/Address:

DFCS County_____

_____
Mailing Address

2. Medicaid Number:

3. Social Security Number

4. Sex | Age | 4A. Birthdate

5. Primary Care Physician

6. Applicant's Telephone #

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 / /

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 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: _____ 11. Date:_____
(***Parent or other Legal Representative)***

Section B – Physician's Report and Recommendation

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

13. Diagnosis — 1. ICD | 2. ICD | 3. ICD

1)_____ 2)_____ 3)_____
(Add attachment for additional diagnoses)

14. **Medications**

Name	Dosage	Route	Frequency

15. **Diagnostic and Treatment Procedures**

Type	Frequency

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

Previous Hospitalizations:_____ Rehabilitative/Habilitative Services:_____ Other Health Services:_____

Hospital Diagnosis: 1)_____ 2) Secondary_____ 3) Other_____

17. Anticipated Dates of Hospitalization: _____/_____ /

18. Level of Care Recommended: ☐ Nursing Facility ☐ ICF/ID 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 be managed by provision of ☐ Community Care or ☐ 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, or ICF/ID

_____Physician's Signature

26. Date signed by Physician

27. Physician's Licensure No.

28. Physician's Telephone #:
( )

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	☐ 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
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	40. Remarks
☐ Five days per week ☐ Less than 5 days per week	

41. Pre-Admission Certification Number	42. Date Signed	43. Print Name of MD or RN:_____ Signature of MD or RN:_____

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:_____ DOB: _____ SS#_____
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):
_____
_____

		Current Needs
	None	Description of Skilled Nursing Needs
Cardiovascular:	____	_____
Neurological:	____	_____
Respiratory:	____	_____
Nutrition:	____	_____
Integumentary:	____	_____
Urogenital:	____	_____
Bowel:	____	_____
Endocrine :	____	_____
Immune:	____	_____
Skeletal:	____	_____
Other:	____	_____

Therapy (Attach current notes) : Speech sessions/wk ____ PT sessions/wk ____ OT sessions/wk ____
Autism Spectrum Services/wk_____

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 __
Nurse in attendance during school day: _____ N/A ____(Attach most recent 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 or facililty whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

Physician's Signature: _____ Date: _____
Primary Caregiver Signature: _____ Date: _____

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

TEFRA/KATIE BECKETT MEDICAL NECCESSITY/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. It may be completed by physician and the primary caregiver.

Member (Applicant) Information
Enter the Member's Name, DOB and SS#.

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

Level of Care
Check the correct box for the recommended level of care.

Medical History
Provide narrative of member's medical history or attach documents (i.e., hospital discharge summary, etc.)

Current Needs
Check member's current needs and provide description of skilled nursing needs.

Therapy
Therapies require a plan of care. All therapies, including school based therapies, must be ordered by a physician and accompanied by current individually signed therapy notes.

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

School
Enter a check for member's appropriate school attendance and IFSP or IEP plan

Signature
The primary care physician or physician of record must sign and date. The caregiver (parent or guardian) must sign and date. Foster Care members must have the signature of the DFCS representative.

Instructions for Completing the Katie Beckett Cost Effectiveness Form

DMA Form 704

This form should be completed by the Katie Beckett child's primary physician.

Instruct the physician to complete the form as follows:

- Patient Name – Enter the name of the Katie Beckett child.
- The MES may provide the Medicaid number, if not known.
- 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.
- 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 the everything applicable, it is permissible to have other medical service amounts entered by the providing agency, pharmacy or therapist; have that entity initial next to the dollar amount; at the very least, the physician must complete the cost of his/her services.
- The physician must indicate if home care will be as good as institutional care.
- 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.
- The form must have an original signature of the primary care physician.
  Stamped signature are not acceptable. The date should be the date of the signature.

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

Supplemental Evaluation Documents

DEVELOPMENTAL EVALUATION (Current no more than 3 years old)

Required for all Children with Developmental Delays-**Ages 0 to 5** such as ones listed below:

Cerebral Palsy, Epilepsy Cerebral, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays.

A Developmental Evaluation may be completed by a Developmental Pediatrician, School Psychologist or Approved Licensed Medical Professionals with one of the following credentials:

PH. D	**M.ED**	**M.A**	**ED.D**
M.S	**ED.S**	**CAS**	**SSP**
CAGS	**PSY.S**	**PSY.D**	**Preschool or Education Diagnostician**

EIS-Early Intervention Specialist with Babies Can't Wait.

The Developmental report MUST be signed by an approved Evaluator and Must contain:

STANDARD SCORES or **AGE EQUIVALENTS** in these **FIVE DOMAINS OF FUNCTION**:

COGNITION, LANGUAGE, MOTOR, ADAPTIVE, and SOCIAL

PSYCHOLOGICAL EVALUATION (Current no more than 3 years old)

Required for all Children with Developmental Delays-**Ages 6 to 18** such as ones listed below:

Cerebral Palsy, Epilepsy Cerebral, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays.

A Psychological Evaluation may be completed by a Developmental Pediatrician, School Psychologist or Approved Licensed Medical Professionals with one of the following credentials:

PH. D	**M.ED**	**M.A**	**ED.D**
M.S	**ED.S**	**CAS**	**SSP**
CAGS	**PSY.S**	**PSY.D**	**Preschool or Education Diagnostician**

The Psychological report **MUST** be signed by an approved Evaluator and **MUST** contain an **IQ** score **AND Adaptive Function testing including an overall Composite Score**.

A current Psychological or Developmental Evaluation is always required when the recommended Level of Care (LOC) is ICF/MR and/or the Behavioral Status, (#33 on form DMA-6A) is anything other than alert and/or cooperative.

Department of Community Health

DCH Centralized Katie Beckett Unit

All therapies whether in school or private setting must be medically necessary.

Please provide supporting documentation:

- Current individual signed and dated therapy notes for the last 90 days.
- Signed physician orders for all therapy sessions.

Failure to provide the supporting documentation by the time requested may result in the closure of your Katie Beckett Medicaid case or denial of your Katie Beckett Medicaid application.

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.

_____ _____

Signature Date

_____

Print Name

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.

_____ _____

Signature Date

_____

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.

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:

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:

LOCAL DFCS OFFICES

DFCS OFFICE	STREET	CITY, STATE	PHONE #
Appling Co. DFCS	2160 W. Parker St.	Baxley, Ga. 31513	912-366-1010
Atkinson Co. DFCS	92 Legion Ave.	Pearson, Ga. 31642	912-422-3242
Bacon Co. DFCS	417 S. Dixon St.	Alma, Ga. 31510	912-632-8375
Baker Co. DFCS	322 Sunset Avenue SW	Newton, Ga. 39870	229-734-5247
Baldwin Co. DFCS	154 Roberson Mill Rd	Milledgeville, Ga.31061	478-455-4135
Banks Co DFCS	423 Evans St.	Homer, Ga. 30547	706-677-2272
Barrow Co. DFCS	16 Lee Street	Winder, Ga. 30680	770-868-4222
Bartow Co. DFCS	47 Brook Dr.	Cartersville, Ga. 30120	770-387-3710
Ben Hill Co. DFCS	124 South Grant Street	Fitzgerald, Ga. 31750	229-426-5300
Berrien Co. DFCS	301 South Jefferson St.	Nashville, Ga. 31639	229-686-5568
Bibb County DFCS	456 Oglethrope St.	Macon, Ga. 31201	478-751-6051
Bleckley Co. DFCS	140 Peacock St.	Cochran, Ga. 31014	478-934-3172
Brantley Co. DFCS	127 Bryan St.	Nahunta, Ga. 31553	912-462-6171
Brooks Co. DFCS	201 South Barnes St.	Quitman, Ga. 31643	229-263-7567
Bryan Co. DFCS	133 West DuBois St.	Pembroke, Ga.31321	912-653-2805
Bulloch Co. DFCS	41 Pulaski Hwy	Statesboro, Ga. 30458	912-871-1333
Burke Co. DFCS	729 W. 6th St.	Waynesboro, Ga. 30830	706-554-7751
Butts Co. DFCS	178 Ernest Biles Drive	Jackson, Ga. 30233	770-504-2200
Calhoun Co. DFCS	28239 Main Street	Morgan, Ga. 39866	229 849-5100
Camden Co. DFCS	800 Charles Gilman Jr Ave.	Kingsland, Ga. 31548	912-729-4583
Candler Co. DFCS	750 South Leroy St.	Metter, Ga. 30439	912-685-2153
Carroll Co. DFCS	165 Independence Dr	Carrollton, Ga. 30116	770 830-2050
Catoosa Co. DFCS	700 City Hall Drive	Fort Oglethorpe, Ga. 30742	706-866-1740
Charlton Co. DFCS	32 Oakwood St.	Folkston, Ga. 31537	912-496-2527
Chatham Co. DFCS	761 Wheaton St.	Savannah, Ga 31402	912-651-2211
Chattahoochee Co. DFCS	209 McNaughton Street	Cusseta, Ga. 31805	706-989-3681
Chattooga Co. DFCS	102 Highway 48	Summerville, Ga. 30747	706-857-0817
Cherokee Co. DFCS	105 Lamar Haley Pkwy	Canton, Ga. 30169	770-720-3610
Clarke Co. DFCS	284 North Avenue	Athens, Ga. 30601	706-227-7002
Clay Co. DFCS	155 Wilson Street Suite 1	Fort Gaines, Ga. 39851	229-768-2511
Clayton Co. DFCS	877 Battlecreek Rd	Jonesboro, Ga. 30236	770-473-2300
Clinch Co. DFCS	17 East Shirley Rd	Homerville, Ga. 31634	912 487-5263
Cobb Co. DFCS	325 South Fairground St	Marietta, Ga. 30060	770-528-5000
Cobb Co. DFCS	590 Commerce Park Dr.	Marietta, Ga. 30060	770-528-5000
Coffee Co. DFCS	1300 West Baker Hwy	Douglas, Ga. 31534	912-389-4285
Colquitt Co. DFCS	449 N. Main St.	Moultrie, Ga. 31768	229-217-4000
Columbia Co. DFCS	6358 Columbia Rd	Appling, Ga. 30802	706-541-1640
Cook Co. DFCS	1010 S. Hutchinson Ave.	Adel, Ga. 31620	229-896-3672
Coweta Co. DFCS	533 Hwy 29 North	Newnan, Ga. 30263	770-254-7234
Crawford Co. DFCS	360 N. Dugger Ave.	Roberta, Ga. 31078	478-836-3060
Crisp Co. DFCS	107 West 23rd. Ave	Cordele, Ga.31010	229-276-2349
Dade Co. DFCS	71 Case Ave.	Trenton, Ga. 30752	706-657-7511
Dawson Co DFCS	424 Hwy 53E	Dawsonville, Ga. 30534	706-265-6598
Decatur Co. DFCS	505 S. Wheat Ave	Bainbridge, Ga. 39819	229-248-2420
DeKalb Co DFCS	178 Sams St.	Decatur, Ga. 30030	404-370-5000
DeKalb Co. DFCS	30 Warren St. SE	Atlanta, Ga. 30317	404 687 3111
Dodge Co. DFCS	1111 Plaza Ave.	Eastman, Ga. 31023	478-374-6760
Dooly Co. DFCS	1022 E. Union Street	Vienna, Ga. 31092	229 268-4111
Dougherty Co. DFCS	200 W. Oglethorpe Blvd.	Albany, Ga. 31706	229-430-4118
Douglas Co. DFCS	8473 Durelee Ln Suite 100	Douglasville, Ga. 30134	770-489-3000
Early Co. DFCS	11850 Columbia Rd.	Blakely, Ga. 39823	229-724-2000
Echols Co. DFCS	105 Church of God St.	Statenville, Ga. 31648	229-559-5751
Effingham Co. DFCS	204 Franklin St.	Springfield, Ga.31329	912-754-6471
Elbert Co. DFCS	P. O. Box 1010	Elberton, Ga 30635-1010	706-213-2001
Emanuel Co. DFCS	143 N. Anderson Dr.	Swainsboro, Ga. 30401	478-289-2400
Evans Co. DFCS	201 Freeman St.	Claxton, Ga. 30417	912-739-1222
Fannin Co. DFCS	990 E. Main St. Suite 10	Blue Ridge, Ga. 30513	706-632-2296
Fayette Co. DFCS	905 Hwy 85 South	Fayetteville, Ga. 30215	770-460-2555
Floyd Co DFCS	450 Riverside Pkwy, Suite 110	Rome, Ga. 30162	706-295-6500
Forsyth Co. DFCS	426 Canton Road	Cumming, Ga. 30028	770-781-6700
Franklin Co DFCS	1133 Hull Ave.	Carnesville, Ga. 30521	706-384-4521
Fulton Co. CNN	84 Walton St.	Atlanta, Ga. 30303	404 657-8000

DFCS OFFICE	STREET	CITY, STATE	PHONE #
Jones Co. DFCS	141 ames St	Gray, Ga. 31032	478-986-3126
Lamar Co. DFCS	122 Westgate Plaza	Barnesville, Ga. 30204	770-358-5170
Lanier Co. DFCS	5 Rocuemore Circle	Lakeland, Ga. 31635	229-482-3686
Laurens Co. DFCS	905 Claxton Dairy Rd.	Dublin, Ga. 31021	478-275-6533
Lee Co. DFCS	122 Fourth St	Leesburg, Ga. 31763	229-759-3090
Liberty Co. DFCS	P.O. Box 710	Hinesville, Ga. 31310	912-370-2555
Lincoln Co. DFCS	171 W. Peachtree St.	Lincolnton, Ga. 30817	706-359-3135
Long Co. DFCS	P.O. Box 369	Ludowici, Ga. 31316	912-545-2177
Lowndes Co. DFCS	206 E. Patterson St.	Valdosta, Ga. 31603	229-333-5200
Lumpkin Co. DFCS	175 Tipton Dr	Dahlonega, Ga. 30533	706-864-1980
Macon Co. DFCS	413 Clifton Bradley Dr.	Oglethorpe, Ga. 31068	478-472-3700
Madison Co. DFCS	P.O. Box 176	Danielsville, Ga. 30633-0176	706-795-2128
Marion Co. DFCS	111 Baker Street, Suite B	Buena Vista, Ga. 31803	229-649-2311
McDuffie Co. DFCS	307 Greenway St	Thomson, Ga. 30824	706-595-2946
McIntosh Co. DFCS	1221 North Way	Darien, Ga. 31305	912-437-4193
Meriweather Co. DFCS	17234 Roosevelt Hwy.	Greenville, Ga. 30222	706-672-4244
Miller Co. DFCS	69 Thompson Town Rd	Colquitt, Ga. 39837	229-758-3387
Mitchell Co. DFCS	90 W. Oakland Ave	Camilla, Ga. 31730	229-572-3500
Monroe Co. DFCS	107 Martin Luther King Jr Drive	Forsyth, Ga. 31029	478-993-3030
Montgomery Co. DFCS	130 E. Spring St.	Mt. Vernon, Ga. 30445	912-583-3722
Morgan Co. DFCS	2005 S. Main Street Suite 100	Madison, Ga. 30650	706-343-5800
Murray Co. DFCS	830 S.R. Maddox Pwy	Chatsworth, Ga. 30705	706-695-7315
Muscogee Co. DFCS	2100 Comer Avenue	Columbus, Ga. 31902	706-649-7311
Newton Co. DFCS	4187 Mill Street	Covington, Ga. 30014	770-784-2490
Oconee Co. DFCS	1400 Greensboro Hwy	Watkinsville, Ga. 30677	706-310-7250
Oglethorpe Co. DFCS	P.O. Box 160	Lexington, Ga. 30648-0160	706-743-8152
Paulding Co. DFCS	1335 Industrial Blvd. North	Dallas, Ga. 30132	770-443-7810
Peach Co. DFCS	705 Spruce St	Fort Valley, Ga. 31030	478-825-6428
Pickens Co. DFCS	251 Chambers St	Jasper, Ga. 30143	706 692-4701
Pierce Co. DFCS	62 Hendry St	Blackshear, Ga. 31516	912-449-6624
Pike Co. DFCS	98 Hwy 19	Zebulon, Ga. 30295	770 567-8427
Polk Co. DFCS	100 County Loop Road	Cedartown, Ga. 30125	770-749-2232
Pulaski Co. DFCS	180 Broad Street	Hawkinsville, Ga. 31036	478-783-5191
Putnam Co. DFCS	673 Godfrey Hwy	Eatonton, Ga. 31024	706-485-6921
Quitman Co. DFCS	1023 Hwy 82	Georgetown, Ga. 39854	229-334-2427
Rabun Co. DFCS	123 Hiawassee St	Clayton, Ga. 30525	706-782-4283
Randolph Co. DFCS	145 North Webster Street	Cuthbert, Ga. 3984	229 732-3742
Richmond Co. DFCS	525 Fenwick St	Augusta, Ga. 30903	706-721-2536
Rockdale Co. DFCS	975 Taylor Street SW	Conyers, Ga. 30012	770-388-5025
Schley Co. DFCS	45 W. Oglethorpe Street	Ellaville, Ga. 31806	229-937-2591
Screven Co. DFCS	116 Singleton Ave.	Sylvania, Ga. 30467	912-564 2041
Seminole Co. DFCS	108 W. Fourth St.	Donalsonville, Ga. 30845	1229 524-2363
Spalding Co. DFCS	411 E. Solomon St	Griffin, Ga. 30223	770-228-4502
Stephens Co. DFCS	64 Boulevard St. Suite 101	Toccoa, Ga. 30577	706-282-4505
Stewart Co. DFCS	2115 E. Broad Street	Lumpkin, Ga. 31815	229-838-4335
Sumter Co. DFCS	1601 N. Martin Luther King, Jr Blvd. Suite 200	Americus, Ga. 31719	229-931-2462
Talbot Co. DFCS	356 Jordan City Road	Talbotton, Ga 31827	706 665-8524
Taliaferro Co. DFCS	187 Commerce St.	Crawfordville, Ga. 30631	706-456-2339
Tattnall Co. DFCS	1.7 N. Main St.	Reidsville, Ga. 30453	912-557-7721
Tattnall Co. DFCS	205 W. Hencart Road	Glennville, Ga. 30427	912-654-5191
Taylor Co. DFCS	178-2 Charing Road/ Hwy 37 West	Butler, Ga. 31006	478-862-5221
Telfair Co. DFCS	33 East Brewton Street	McRae, Ga. 31055	229-868-3030
Terrell Co. DFCS	642 Randolph Ave.	Dawson, Ga. 39842	229-995-4431
Thomas Co. DFCS	450 Smith Ave	Thomasville, Ga. 31792	229-225-4005
Tift Co. DFCS	410 W. 2nd St.	Tifton, Ga. 31794	229-386-3388
Toombs Co. DFCS	152 Orley Dr.	Lyons, Ga. 30436	912-526-8117
Towns Co. DFCS	1520 US 76 West, Suite 4	Hiawassee, Ga. 30546	706-896-3524
Treutlen Co. DFCS	1831 MLK JR. Dr	Soperton, Ga. 30457	912-529-3757
Troup Co. DFCS	1220 Hogansville Rd	LaGrange, Ga. 30241	706-298-7100
Turner Co. DFCS	336 North St	Ashburn, Ga. 31714	229-567-4353
Twiggs Co. DFCS	14 Cedar Lane	Jeffersonville, Ga. 31044	478-945-3758
Union Co. DFCS	152 Blue Ridge Hwy	Blairsville, Ga. 30512	706-781-2381

LOCAL DFCS OFFICES

DFCS OFFICE	STREET	CITY, STATE	PHONE #
Fulton Co. Grady Clinic	341 Ponce De Leon Ave. NE	Atlanta, Ga 30308	404-616-6863
Fulton Co. NFSC	5075 Roswell Rd. NE	Atlanta, Ga. 30328	404-252-2180
Fulton Co. NWSC	1249 Donald Lee Hollowell Pkwy	Atlanta, Ga 30318	404-206-5600
Fulton Co. SFSC	5710 Stonewall Tell Rd.	College Park, Ga. 30349	770-774-7500
Fulton Co. SWSC	515 Fairburn Rd.	Atlanta, Ga. 30331	404-699-4337
Gilmer Co. DFCS	54 Kiker Street	Ellijay, Ga. 30540	706-635-2351
Glascock Co. DFCS	674 West Main St.	Gibson, Ga. 30810	706-598-2955
Glynn Co. DFCS	4420 Altama Ave. Suite #9	Brunswick, Ga. 31520	912-262-3200
Gordon Co. DFCS	619 Mauldin Rd. NW	Calhoun, Ga. 30701	706-624-1200
Grady Co. DFCS	250 2nd Ave. SE	Cairo, Ga 39828	229-377-3154
Greene Co. DFCS	1951 S. Main Street	Greensboro, Ga. 30642	706-453-2365
Gwinnett Co. DFCS	One Justice Square 446 West Crogan St. Suite 300	Lawrenceville, Ga. 30046	678-518-5500
Gwinnett Co. (Buford)	2755 Sawnee Ave. NE Suite B-001	Buford, Ga 30518	770-614-2500
Gwinnett Co. (Norcross)	2211 Beaver Ruin Rd., Suite 130	Norcross, Ga. 30071	770-441-8800
Gwinnett Co. (South Clayton)	33 Clayton Street, Suite 100	Lawrenceville, Ga. 30046	770-339-5111
Habersham Co. DFCS	1045 Grant St.	Clarkesville, Ga. 30523	706-754-2148
Hall Co. DFCS	970 McEver Rd. Ext.	Gainesville, Ga. 30504	770-532-5298
Hancock Co.DFCS	12744 Broad St.	Sparta, Ga. 31087	706-444-1203
Haralson Co. DFCS	21 Magnolia St.	Buchanan, Ga. 30113	770-646-3885
Harris Co. DFCS	134 North College Street	Hamilton, Ga. 31811	706-628-4226
Hart Co. DFCS	267 E. Johnson St.	Hartwell, Ga. 30543	706-856-2740
Heard Co. DFCS	1188 Franklin Hwy.	Franklin, Ga. 30217	706-675-3361
Henry Co. DFCS	125 Henry Pkwy	McDonough, Ga.30253	770-954-2014
Houston Co. DFCS	92 Cohen Walker Dr.	Warner Robins, Ga. 31088	478-988-7600
Irwin Co. DFCS	108 North Irwin Ave.	Ocilla, Ga. 31774	229-468-2150
Jackson Co. DFCS	456 Athens Street	Jefferson, Ga. 30549	706-367-3000
Jasper Co. DFCS	226 Funderburg Drive	Monticello, Ga. 31064	706-468-6461
Jeff Davis Co. DFCS	40 E. Sycamore St.	Hazlehurst, Ga. 31539	912-375-3942
Jefferson Co. DFCS	2459 US Hwy #1 North	Louisville, Ga. 30434	478-625-7259
Jenkins Co. DFCS	618 S. Gray St.	Millen, Ga. 30442	478-982-1944
Johnson Co. DFCS	44 West Court St	Wrightsville, Ga. 31096	478-864-4210

DFCS OFFICE	STREET	CITY, STATE	PHONE #
Upson Co. DFCS	711 N. Bethel St.	Thomaston, Ga. 30286	706-646-6043
Walker Co. DFCS	10056 N. HWY 27	Rock Spring, Ga. 30739	706-375-0726
Walton Co. DFCS	P.O. Box 927	Monroe, Ga. 30655	770-207-4000
Ware Co. DFCS	1200 Plant Ave.	Waycross, Ga. 31502	912-285-6040
Warren Co. DFCS	408 Highway 80 N.	Warrenton, Ga. 30828	706-465-3326
Washington Co. DFCS	1124 S. Harris St.	Sandersville, Ga. 31082	478-553-2350
Wayne Co. DFCS	1220 S. First St.	Jesup, Ga. 31598	912-427-5866
Webster Co. DFCS	6816 Washington Street	Preston, Ga. 31824	229-828-6265
Wheeler Co. DFCS	44 West Third Ave.	Alamo, Ga 30411	912-568-7127
White Co. DFCS	1241 Helen Hwy., Suite 200	Cleveland, Ga. 30528	706-865-3128
Whitfield Co. DFCS	1142 N. Thorton Ave.	Dalton, Ga. 30720	706-272-2331
Wilcox Co. DFCS	453 Second Ave.	Rochelle, Ga. 31079	229-365-2243
Wilkes Co. DFCS	48 Lexington Avenue	Washington, Ga. 30673	706-678-2814
Wilkinson Co. DFCS	103 Payne St.	Irwinton, Ga. 31042	478-946-2224
Worth Co. DFCS	503 N. Henderson St.	Sylvester, Ga. 31791	229-777-2000

Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance.

The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at 404-657-3433 or DCH at 678-248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dhs.georgia.gov/forms-notices, or you may obtain the DCH ADA Reasonable Modification Request Form at the DCH Katie Becket Team office or online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, but you do not have to use a form.

How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street N.W., Ste 19-454, Atlanta, GA, 30303, 404-657-3735. For DCH, contact the KB TEAM ADA/Section 504 Coordinator at 5815 Live Oak Pkwy Suite 2-F, Norcross, GA, 30093, 678-248-7449.

You can ask your case worker for a copy of the DFCS civil rights complaint form. The complaint form is also available at https://dhs.georgia.gov/documents/dfcs-discrimination-complaint-form-0. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the "USDA-HHS Joint Nondiscrimination Statement" included within.

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

Notificación de la ADA/Derechos de la Sección 504

Ayuda para personas con discapacidad

La ley federal* exige que el Departamento de Servicios Humanos de Georgia y el Departamento de Salud Comunitaria de Georgia ("los Departamentos") brinden a las personas con discapacidad la misma oportunidad de participar y reunir los requisitos para los programas, los servicios o las actividades de los Departamentos. Esto incluye programas como SNAP (Programa de Asistencia Nutricional Suplementaria), TANF (Asistencia Temporal para Familias Necesitadas) y Asistencia Médica.

Los Departamentos brindan modificaciones razonables cuando son necesarias para evitar la discriminación basada en la discapacidad. Por ejemplo, podemos cambiar políticas, prácticas o procedimientos para brindar acceso equitativo. Para garantizar una comunicación igualmente efectiva, brindamos asistencia de comunicación a las personas con discapacidad o sus acompañantes con discapacidad, como intérpretes de lengua de señas. Nuestra ayuda es gratis. Los Departamentos no están obligados a realizar ninguna modificación que resulte en una alteración fundamental en la naturaleza de un servicio, un programa o una actividad o en cargas financieras y administrativas indebidas.

Cómo solicitar una modificación razonable o asistencia de comunicación

Comuníquese con su asistente social si tiene una discapacidad y necesita una modificación razonable, asistencia de comunicación o ayuda adicional. Por ejemplo, llame si necesita ayuda o servicio para una comunicación efectiva, como un intérprete de lengua de señas. Puede comunicarse con su asistente social o llamar al DFCS (Departamento de Servicios para la Familia y los Niños) al 404-657-3433 o al DCH (Departamento de Salud Comunitaria) al 678-248-7449 para hacer su solicitud. También puede realizar su solicitud utilizando el formulario del DFCS para solicitud de modificación razonable en virtud de la ADA (Ley para Estadounidenses con Discapacidades), que está disponible en la oficina local del DFCS o en línea en https://dhs.georgia.gov/forms-notices. Además, puede obtener el formulario del DCH para solicitud de modificación razonable en virtud de la ADA en la oficina del equipo Katie Becket del DCH o en línea en https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, pero no es necesario usar un formulario.

Cómo presentar una queja

Tiene derecho a presentar una queja si los Departamentos lo han discriminado por su discapacidad. Por ejemplo, puede presentar una queja por discriminación si ha solicitado una modificación razonable o un intérprete de lengua de señas que se le hayan negado o que no se hayan resuelto en un plazo razonable. Puede presentar una queja verbalmente o por escrito comunicándose con su asistente social, la oficina local del DFCS o el coordinador de derechos civiles y de la ADA/Sección 504 del DFCS en 2 Peachtree Street N.W., Ste 19-454, Atlanta, GA, 30303, 404-657-3735. Para el DCH, comuníquese con el coordinador del equipo KB y la ADA/Sección 504 en 5815 Live Oak Pkwy Suite 2-F, Norcross, GA, 30093, 678-248-7449.

Puede pedirle a su asistente social una copia del formulario de queja de derechos civiles del DFCS. El formulario de queja también está disponible en https://dhs.georgia.gov/documents/dfcs-discrimination-complaint-form-0. Si necesita ayuda para presentar una queja por discriminación, puede comunicarse con el personal del DFCS mencionado anteriormente. Las personas sordas o con problemas de audición, o que tengan discapacidades del habla, pueden llamar al 711 para que un operador se conecte con nosotros.

También puede presentar una queja por discriminación ante la agencia federal correspondiente. La información de contacto del Departamento de Agricultura de los EE. UU. (USDA) y del Departamento de Salud y Servicios Humanos de los EE. UU. (HHS) se encuentra dentro de la "Declaración conjunta de no discriminación del USDA-HHS" incluida.

**La Sección 504 de la Ley de Rehabilitación de 1973, la Ley para Estadounidenses con Discapacidades de 1990 y la Ley de Enmiendas de la Ley para Estadounidenses con Discapacidades de 2008 garantizan que las personas con discapacidad no sufran discriminación ilegal.*