## Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUC'	TIONS:						· · · · · · · · · · · · · · · · · · ·	<del></del>		
1. Read the ap	plication car	efully & a	answer each	quest	tion acci	urately	v. Attach ad	ditional pages i	f needed.	
2. Sign and n	nail applicat	ion to:					County 1			
	er application		CS							
office in your	county of resi	dence)							<del></del>	
			<del>-</del>		· · · · · · · · · · · · · · · · · · ·					
			AT	TN:						
3. A telephon	e interview ma	ay be requi	ired for these	e progr	ams. Be	sure fe	n enter phone	# below		
4. The DFCS	Medicaid Spec	ialist will	review this a	ipplica	tion. If i	t appea	ars that you m	av be eligible fo	r full Medic	aid
coverage, t	he Medicaid S	pecialist v	vill contact y	ou for	more inf	ormati	ion and verifi	cations.		
PERSONAI	L <b>INFORM</b>	IATION	N: You ma	y hav	ve som	eone	help you c	omplete this	applicatio	n.
Applicant's N	lame (Last, F	irst, Midd	lle Initial)					a person to act		
	. ,	•	,		co	molet	e the inform	ation below:	on your bo	iaii,
Mailing Addr	ess							fiddle Initial)		
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Phone		County				one	<del></del>		· .	
E-Mail Addre	ss				1		Address			
Nursing Facil	ity (if applica	ıble)					ship to Indiv	/idual	<del>-</del> <u></u> -	
							-			
COMPLET	E THIS IN	FORM	ATION F	OR	YOU A	ND	YOUR SE	OUSE.	<del></del>	
Name (Self):			Birthdate	Sex			S. Citizen	Social Secur	ity Ma	rital
						(2	(es or No)	Number	Sta	
Maiden/other	name(s):						ŕ			
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Name (Spous	e):									
Maidan/athan										
Maiden/other	name(s):	}								
L				<u> </u>						
Are you applyi	ng for your s	pouse, too	o?   Yes		No					
Are you blind	or disabled? I	□ Yes	□ No - Is	your s	pouse b	lind o	r disabled? [	□ Yes □ No		
LIVING AF	RRANGEM	IENT: (	Check the	box(e	es) that	best	describes	vour current :	situation	
Living In	Nursing	Another	's Hospic	ce	Hospita	al	Katie	Community	Assisted	Other/
Own Home	Facility	Home					Beckett	Care	Living	Renting
	Date				Date			Date		
	Admitted:			1	Admitte	ed:		Admitted:		
									<u> </u>	_1

HEALTH INSURANCE:	1					
Do you have Medicare?	Type of C	Coverage	Effective Da	te:		you ever
□ Yes □ No		A □ Part B				ed SSI?
Are you enrolled in a Medicare	(hospital		   Medicare Nu	mbor	□ Yes	
HMO or Medicare Drug program?	$\bigcap$ Part $\Gamma$ (RX)		ivieuicare Nu		-	when did it
☐ Yes ☐ No	· · · · · · · · · · · · · · · · · · ·	. <u>.                                   </u>	TICC TO		end?_	
Does your spouse have	Type of C	_	Effective Da	te:	-	our spouse
Medicare?	☐ Part A	A □ Part B	-			eceived SSI?
☐ Yes ☐ No	□ Dowt 3	D.	Medicare Nu	ımher:	□ Yes	
	☐ Part 1	U	wiedleare re	mico.	-	when did it
					end?_	
Do you have other health insurant Does your spouse have other health you answered yes to either of Health Insurance.	alth insuran these quest		es   No  mplete the fo	llowing i		ation:
Company Nam		(Hospital, M	~	Date		Number
Address, and T	-	, <u> </u>	Drugs, Major	- E		1 10111001
Number	1	Medical,)	<i>8.</i> 7. 3			
Self						
Spouse		<u>                                     </u>				
Spouse						
Attach copies (front and back)	of Medica	re and insura	ince cards if a	applicab	le.	
REAL PROPERTY: Do you ow	n all or part	of any real es	state in which	von do r	ot live	?□ Ves □ No
If yes, please complete the follow						
home in which you live.		in proof of roa		iot Abt ti	ic iiou	se or mobile
Address				Value	A	mount Owed
Da vara an anna an	. 4	4		<u></u>	1 1'	1
Do you or your spouse own a car						·
☐ Yes ☐ No If yes, please con	nplete the f	following info	rmation about	each ve	hicle.	Attach
additional pages if needed.	ear Make	Model	Value		<b>A</b>	
Type	Cai IVIaKt	Model Model	Valu	.e	Amo	ount Owed
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RESOURCES: Chesomeone else. Inclupages if necessary.  Do you or your sport Checking account Savings account Government bonds Trust funds Have you or your self you answered yes  Type of Resource  Do you or your sport	Use have and Yes  ☐ Yes	ny of the form No No No away any ese question ount/ Polimber	Puner Buria Stock Other assets tons, des	g resource al plans, al plots on sand bo (IRA, CI for less to Cribe be Value	es? prepaid b contracts nds promissor han its val	urial item  y note, etc.)  ue?  ch addition	□ Ye □ Ye □ Ye □ Ye □ Ye al page	es
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Type of Resource  Do you or your spou	Acc Nur	ese question of the country of the c	ons, des	Value	low. Attac Name	h addition	□ Yenal page	es □ No es if necessary. ee Company,
Do you or your spou	Nur	nber		value	Name	ch addition of Bank, I	nal page	es if necessary.
Do you or your spou	Nur	nber		value	Name	of Bank, I	nsuranc	ce Company,
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Do you or your spou	ise have a lit	fe incuranc	1.	-l				
		io maurani	te notici	<i>37</i>		r-	187	
It yes, please comple	ete the follo	wing infor	mation.	, . Attach	additional	nages if n	Yes	□ <b>No</b>
Policy Owner	Insuranc	ce Compar	ıy				ace	Cash Value
				J	<b></b>		alue	Casii value
•								
				·				
DICOME LATE		<del></del>						
INCOME AND EA	ARNINGS:	List all typ	es of ea	ırnings a	nd income	that you a	and you	r spouse
receives. List the in	come amou	nt before d	leductio	ns (such	as taxes, i	nsurance,	or Med	icare
premiums) are taken Social Security	i out. Attaci	additiona n	al pages	if neede	d. Income	includes,	but is n	ot limited to:
Railroad Retirement	t Benefits	SSI Vet	erans' F	Ponofita				nployment
Pensions/ Retiremen				me Paid	to Vou	1 rust or	Annuit	y Payments
	pe of	Source o			Amount	How Of	arries/ N	Mineral Rights laim Number
	ome	Name of			mount	Received		f applicable)
Receives				,		(weekly,	·	r appricable)
Income						monthly,	etc.)	
								<del></del>
		<u> </u>		_		<u> </u>		
Are you a veteran?				a vetera	ın? 🗆 <b>Y</b>	es 🗆 N	<b>lo</b>	
Where did you and	spouse work	in the pas	st?					<del>-</del>
Do you or your spoı	use have any	v unpaid m	edical b	oills?	□ Yes	□ No		

### PRIVACY STATEMENT:

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

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

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

### APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

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

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

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

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

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

#### APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

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

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

#### **DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS**

Georgia Department of Human Services Division of Family and Children Services

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

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

Nama	Manager at the state of the sta	U.S. Citizen	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S
Name	Place of Birth(city,state,country)	(check which	hever applies)	(If applicable)
I,	attest to the identity o	f the child/ch	ildron listed a	<b>.</b>
(PRINT NAME)				
certify under pena	llty of perjury, that the information was	written and cl	necked above	is true
	·			io acco.
SIGNATURE (PA	ARENT/GUARDIAN)		ATE)	
SIGNATURE (PA	ARENT/GUARDIAN)	(E		
SIGNATURE (PA		(E		·
SIGNATURE (PA	ARENT/GUARDIAN)	Œ BENEFI	TS	Date Naturalized
SIGNATURE (PA	ARENT/GUARDIAN)	(E	TS  Lawfully Admitted	Date Naturalized or Admitted into U.S
	ADULT(S) SEEKING	U.S. Citizen	Lawfully Admitted Immigrant	or Admitted into U.:
SIGNATURE (PA	ARENT/GUARDIAN)	U.S. Citizen	TS  Lawfully Admitted	
	ADULT(S) SEEKING	U.S. Citizen	Lawfully Admitted Immigrant	or Admitted into U.
	ADULT(S) SEEKING	U.S. Citizen	Lawfully Admitted Immigrant	or Admitted into U.:
	ADULT(S) SEEKING	U.S. Citizen	Lawfully Admitted Immigrant	or Admitted into U.
Name	ADULT(S) SEEKIN(  Place of Birth(city,state,country)  certify under penalt	U.S. Citizen (check which	Lawfully Admitted Immigrant never applies)	or Admitted into U.  (If applicable)
Name  I,(PRINT NAME	ADULT(S) SEEKING  Place of Birth(city,state,country)  certify under penalte	U.S. Citizen (check which	Lawfully Admitted Immigrant never applies)	or Admitted into U.i
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