EDUCATION & TRAINING
Services Section

GEORGIA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF FAMILY & CHILDREN SERVICES

ABD Medicaid Phase II SUCCESS

For New Family Independence Workers

Participant Guide

June 11, 2009

SUCCESS Participant Guide

Introduction

Objectives

At the conclusion of this module, the participant will be able to:

- √ paraphrase the expectations of their fellow learners and trainers.
- √ explain the format for this class; especially how it differs from Phase 1 training.
- √ referring to instructions provided, sign on to ODIS, the online policy manual.
- √ name three keys to SUCCESS security.

Outline

I. Welcome & Housekeeping Information

II. Registration

III. Training Goals, Objectives and Outline

IV. Format and Learning Approach

V. Expectations

VI. Accessing & Navigating ODIS – The Online Policy Manual

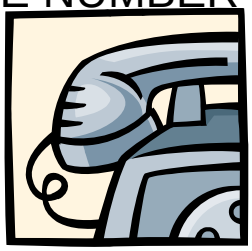
VII. SUCCESS Basics and Security

Welcome to SUCCESS Training!

The purpose of this course is to provide you with the necessary knowledge and skill to use a variety of SUCCESS screens and functions to perform your job when you return to the county. You will not learn all there is to know about SUCCESS, but you will be able to perform the daily tasks required for your job. SUCCESS is a very large system and performs complex tasks. Some of the learning process will take place on the job. This training is designed to be an interactive hands-on training that integrates the application of ABD Medicaid policy with the SUCCESS system. With each section there will be full support, partial support and an opportunity for you to practice what you have learned by completing cases independently.

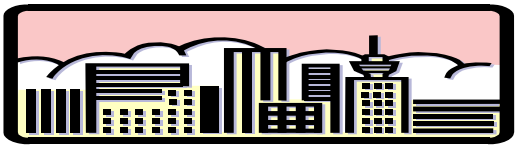
WHAT'S THE BUZZ

- SUCCESS LAB TELEPHONE NUMBER



- HOUSEKEEPING REGISTRATION

- PLACES TO EAT



- EXPECTATIONS

EDUCATION AND TRAINING SERVICES SECTION

DEPARTMENT OF FAMILY AND CHILDREN SERVICES TRAINING PROGRAMS

CLASSROOM STANDARDS, EXPECTATIONS AND ATTENDANCE POLICY

As professional employees with the Department of Human Resources (DHR), Division of Family and Children Services (DFCS), all participants in any DFCS training programs must abide by the DHR Standards of Conduct, which set forth acceptable and unacceptable conduct toward peers, supervisors, managers, and clients. Trainees are encouraged to review the DHR Standards of Conduct found at:

http://www2.state.ga.us/departments/dhr/ohrmd/Policies/1201.pdf

The standards and expectations for the professional behavior of trainees in the classroom are as follows:

When Division employees are in training, their conduct must reflect their commitment and service to DHR and DFCS. Time spent in the classroom and in field practice is a normal workday.

Trainers serve in a supervisory role in the classroom. Responding to the trainer in accordance with the DHR Standards of Conduct is standard operating procedure.

Trainees are expected to complete written tests that cover material presented in class.

Trainees are expected to behave in a respectful manner. Examples of behaviors that are unacceptable and will not be tolerated include the following:

- inattentiveness during classroom time as exhibited by holding side conversations, conducting personal business, reading outside material or sleeping;
- personal attacks, use of offensive language, argumentativeness, or excessive talking;
- use of the Internet for reasons other than classroom activity;
- eating food while in the computer lab;
- use of cell phones, radios or beepers during class. All such devices must be turned off during class and replies to calls must be made during official breaks.

Engaging in these behaviors or in any behavior deemed disruptive or inappropriate by the trainer may result in an immediate conference with the trainer, notification to the

trainee's immediate supervisor, administrator or director, or expulsion from class. The trainer will confer with the appropriate authority prior to expelling a trainee from class.

Trainees are expected to dress in accordance with Personal Appearance During Work Hours per section IV of the DHR Employee Handbook as follows:

> *While the Department does not specify a Department-wide dress code, employees are expected to be clean and neat in appearance during work hours. As representatives of the State, employees should present a business-like professional image. Dress code policies may be established by DHR organizational units. In certain types of jobs, employees may be required to wear uniforms.*
>
> *DHR organizations units may designate specific days as "casual days". Dress on casual days may be less formal, but should always be clean, neat and suitable for the work place.*
>
> *If lettered or illustrated clothing is worn, it should not promote a particular political, moral, religious, personal or other opinion. Clothing which is obscene, vulgar, offensive or inflammatory is prohibited. Employees may be required to change inappropriate dress or instructed not to wear the same or similar clothing in the future. Employees who do not comply with established dress code standards may be subject to disciplinary action, up to and including separation.*

Trainees are encouraged to review the DHR Employees Handbook at:

http://www2.state.ga.us/departments/dhr/ohrmd/Publications/index.html

In addition to adhering to the Classroom Standards and Expectations, the following attendance policies apply to all staff while engaged in any training:

Trainees are expected to arrive on time and adhere to the time allotted for breaks and lunch. If an emergency arises that warrants arriving late or leaving early, the trainee must address the emergency with the trainer in concert with approval from the supervisor.

Annual leave should not be requested and cannot be approved during training. Any exceptions must be discussed with the appropriate authority prior to training. The only acceptable excuses for being absent from classroom training are the following:

Sick leave (e.g. emergency illness or medical appointments for acute illnesses). In the case of sick leave, trainees must notify their immediate supervisor in the county office as soon as possible to report their absence from classroom training.

OR

Court leave (e.g. subpoena to court, unexcused jury duty). In the case of court leave, trainees must obtain prior approval from their immediate supervisor in the county office as soon as possible in order to be absent from classroom training.

The county supervisor or administrator is the only employee who can approve a trainee's leave request. For Centralized Hire trainees, the administrative supervisor is the only employee authorized to approve a trainee's leave request. The trainer/facilitator **will NOT** approve any leave.

The county supervisor must notify the appropriate authority as soon as possible that a trainee will be absent from class due to sick or court leave. The appropriate authority will notify the trainer of the absence.
Trainees absent from class due to approved sick or court leave may be required to make up all or part of the course depending on the length of the absence and the length of the course. This may affect time frames for their completion of training. The appropriate authority will determine with the trainer whether a trainee will continue a course, after consultation with the trainee's supervisor.

For the purposes of determining expulsion from a class, notification regarding leave, or continuation in a class, the appropriate contact via an e-mail is:

- For attendance at any Office of Financial Independence training e-mail: OFItraining@dhr.state.ga.us

- For attendance at any Social Services training e-mail: SStraining@dhr.state.ga.us

I _____ have read and understand the Classroom Standards, Expectations and Attendance Policy for DFCS training programs.

Signature _____ Date _____

EDUCATION AND TRAINING SERVICES SECTION

DIVISION OF FAMILY AND CHILDREN SERVICES TRAINING PROGRAMS

CLASSROOM STANDARDS, EXPECTATIONS AND ATTENDANCE POLICY

SIGNATURE PAGE

I, _____, have read and understand the Classroom Standards, Expectations and Attendance Policy for DFCS training programs.

Signature _____

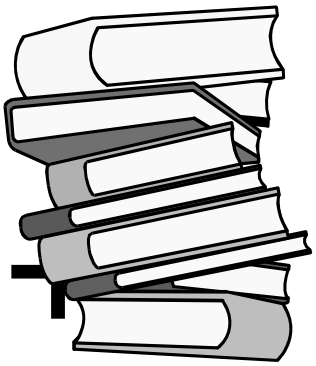
Date _____

SUCCESS Computer Labs

In an effort to keep the computer equipment in good working condition, the following rules apply:

- Please **do not** change the home page for the internet.
- Please **do not** surf the web while in class.
- Please **do not** download any kind of information to the computers. This includes screen savers.
- Please **do not** eat or drink in the computer labs.
- Please remove all disks before shutting down the computers.
- Please shut down each computer at the end of each day.
- Please **do not** place stickers or post it notes of any kind on the computers, monitors or printers.
- Please **do not** write in pencil, pen, marker or otherwise on the computers, monitors, printers or desks.

Accessing the On-line Policy Manual

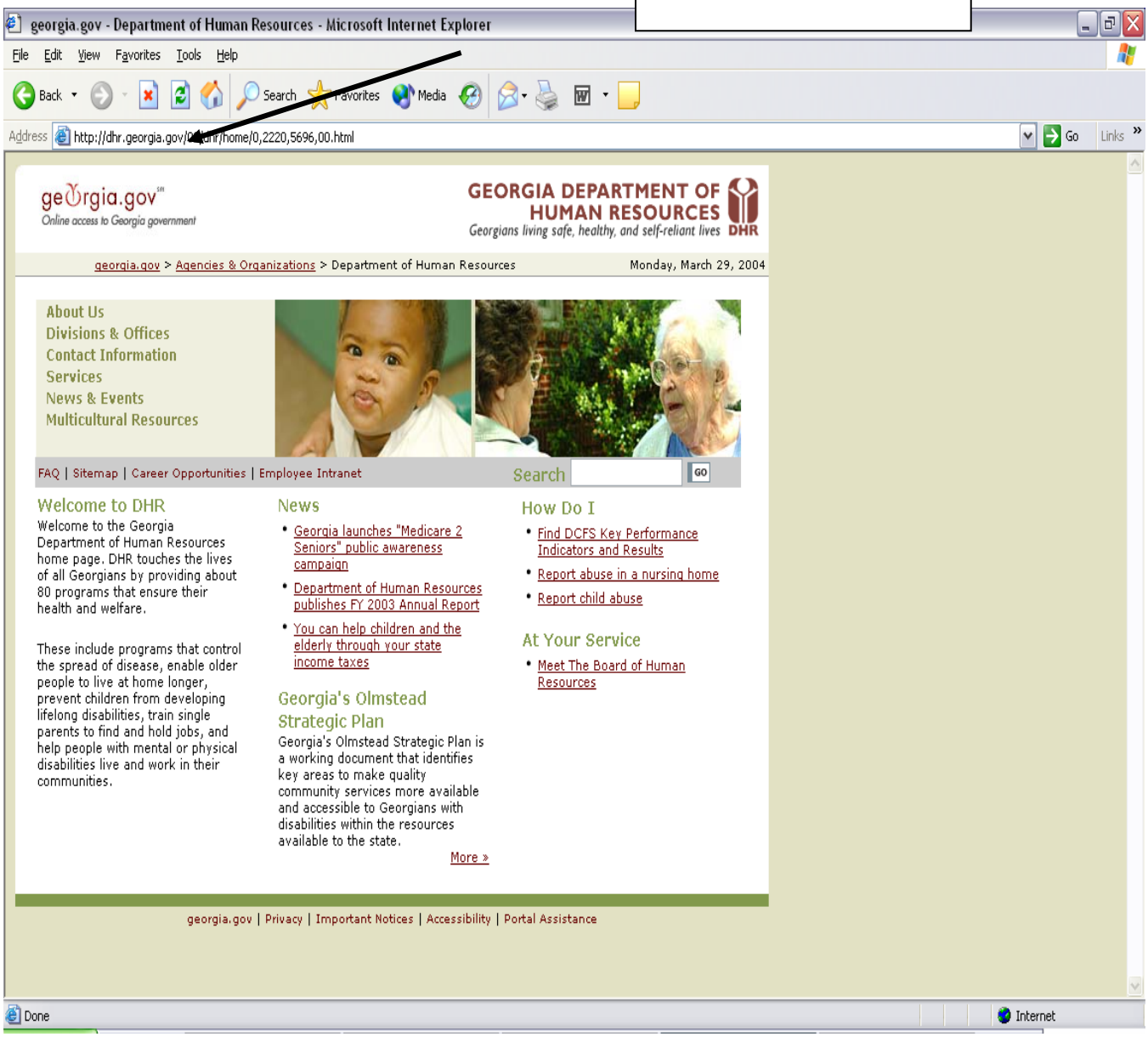


www.odis.dhr.state.ga.us

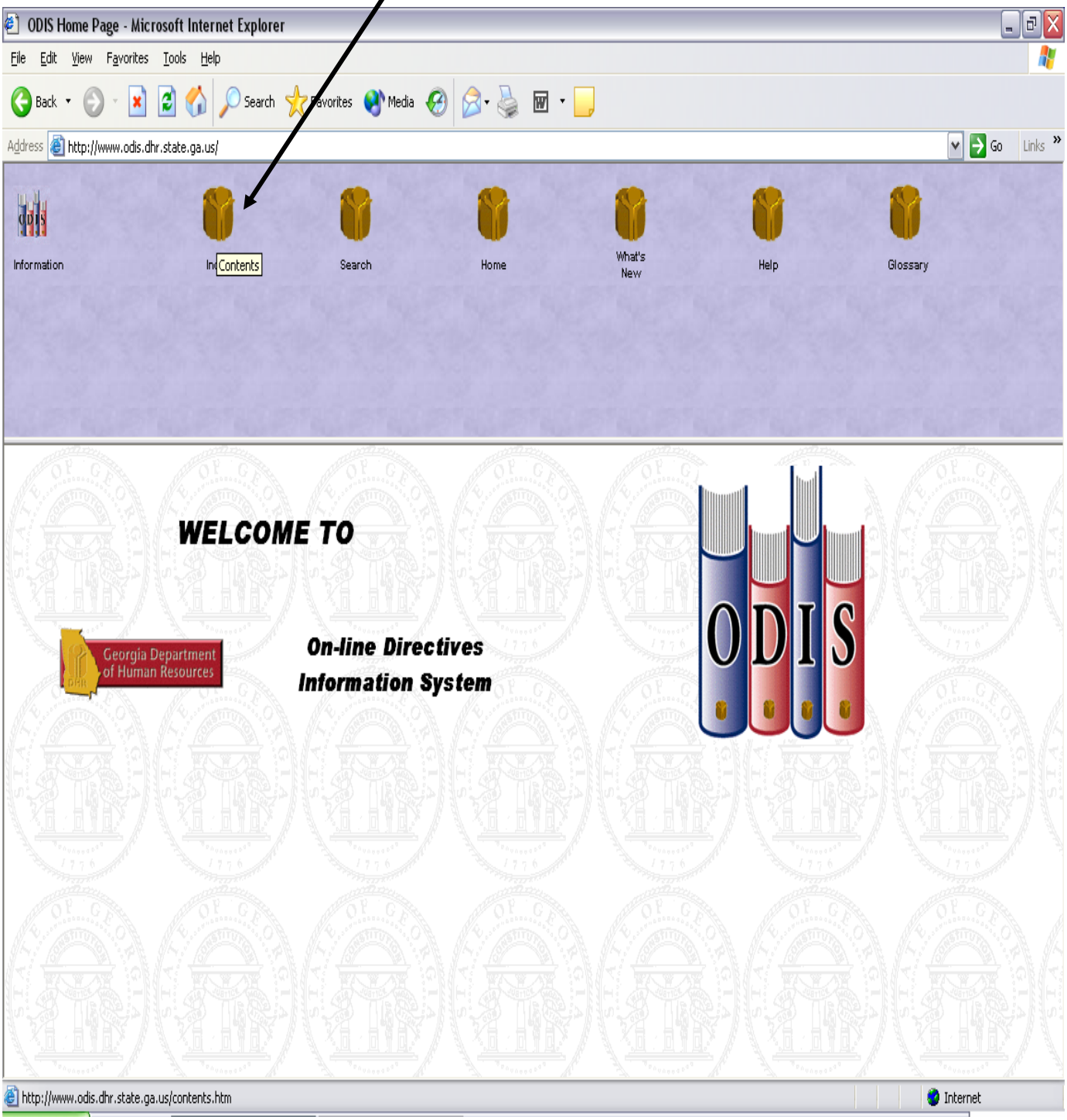
Accessing the on-line policy manual
Step by Step

Step 1: Open Internet Explorer

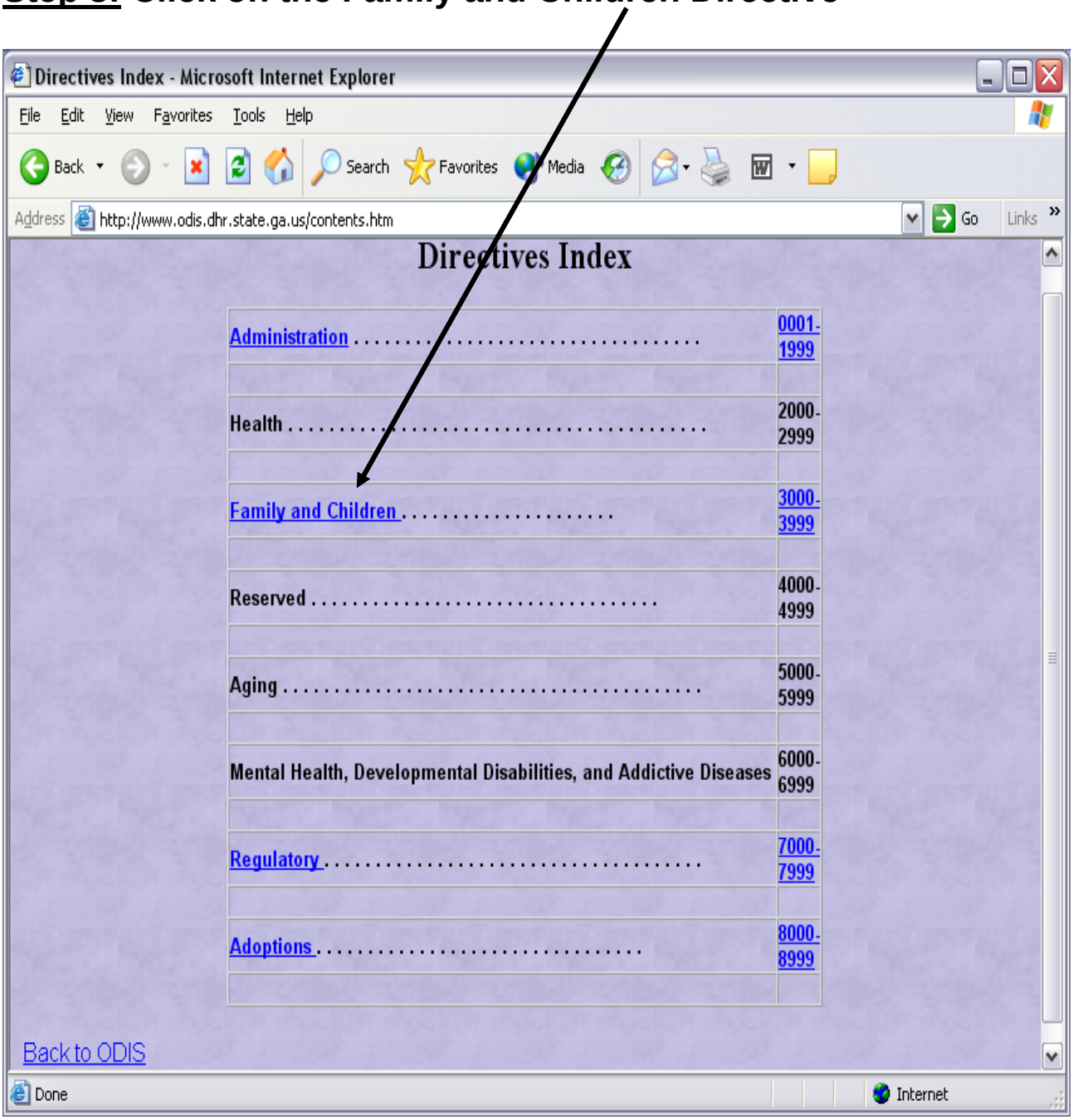
Type the address www.odis.dhr.state.ga.us and press enter



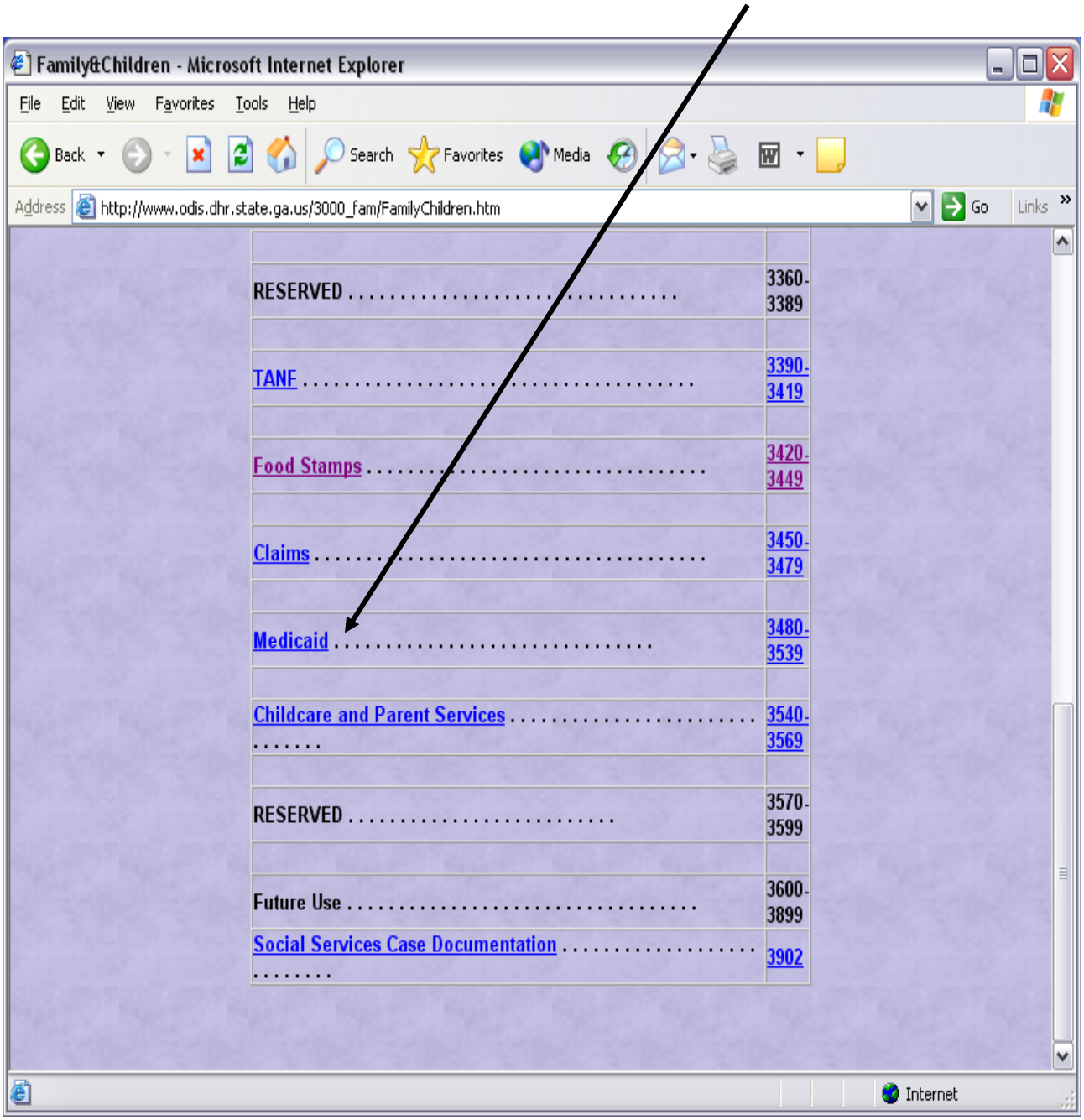
Step 2: Click the Index icon



Step 3: Click on the Family and Children Directive

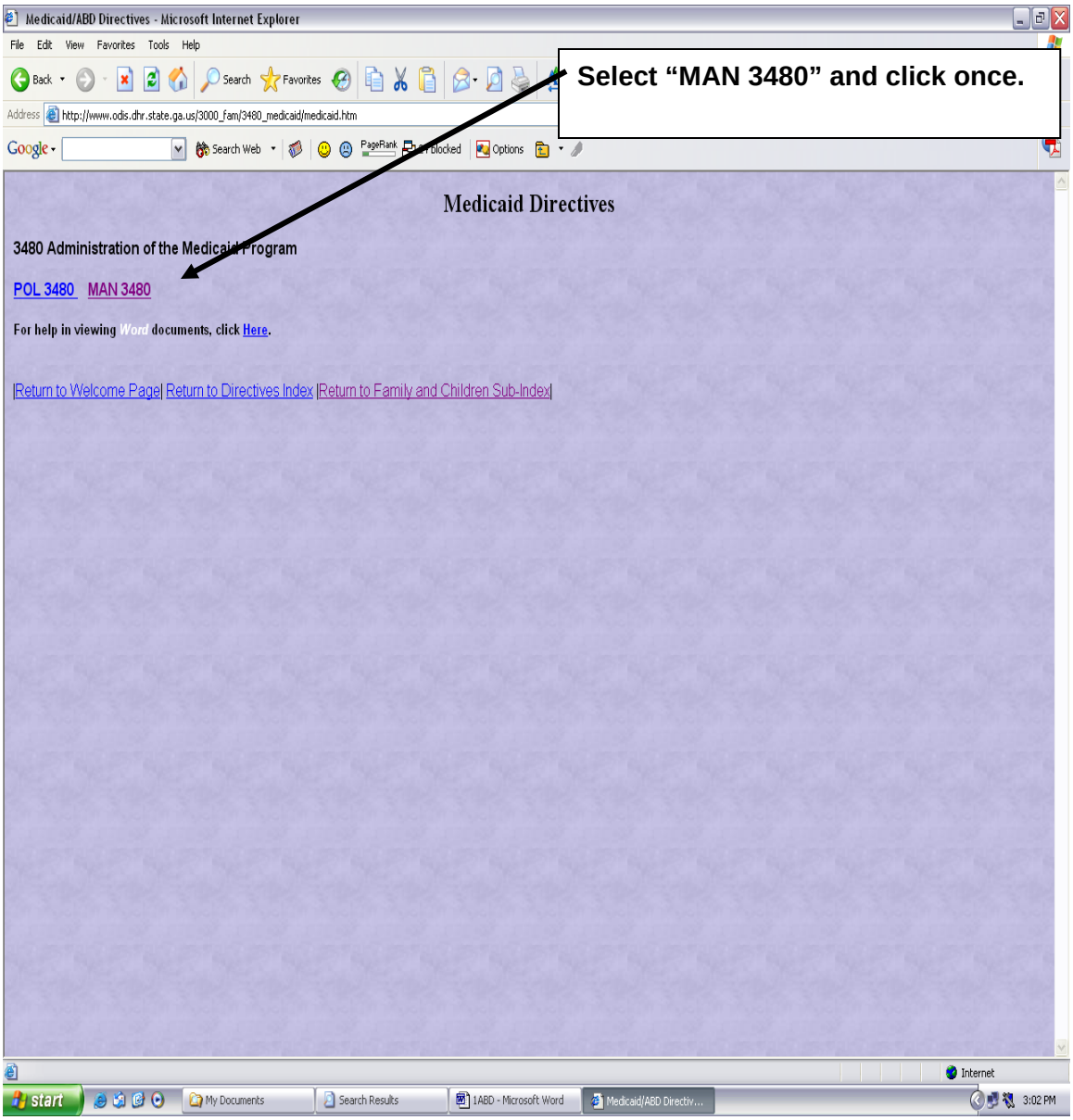


Step 4: Scroll to the Medicaid Directives and click once



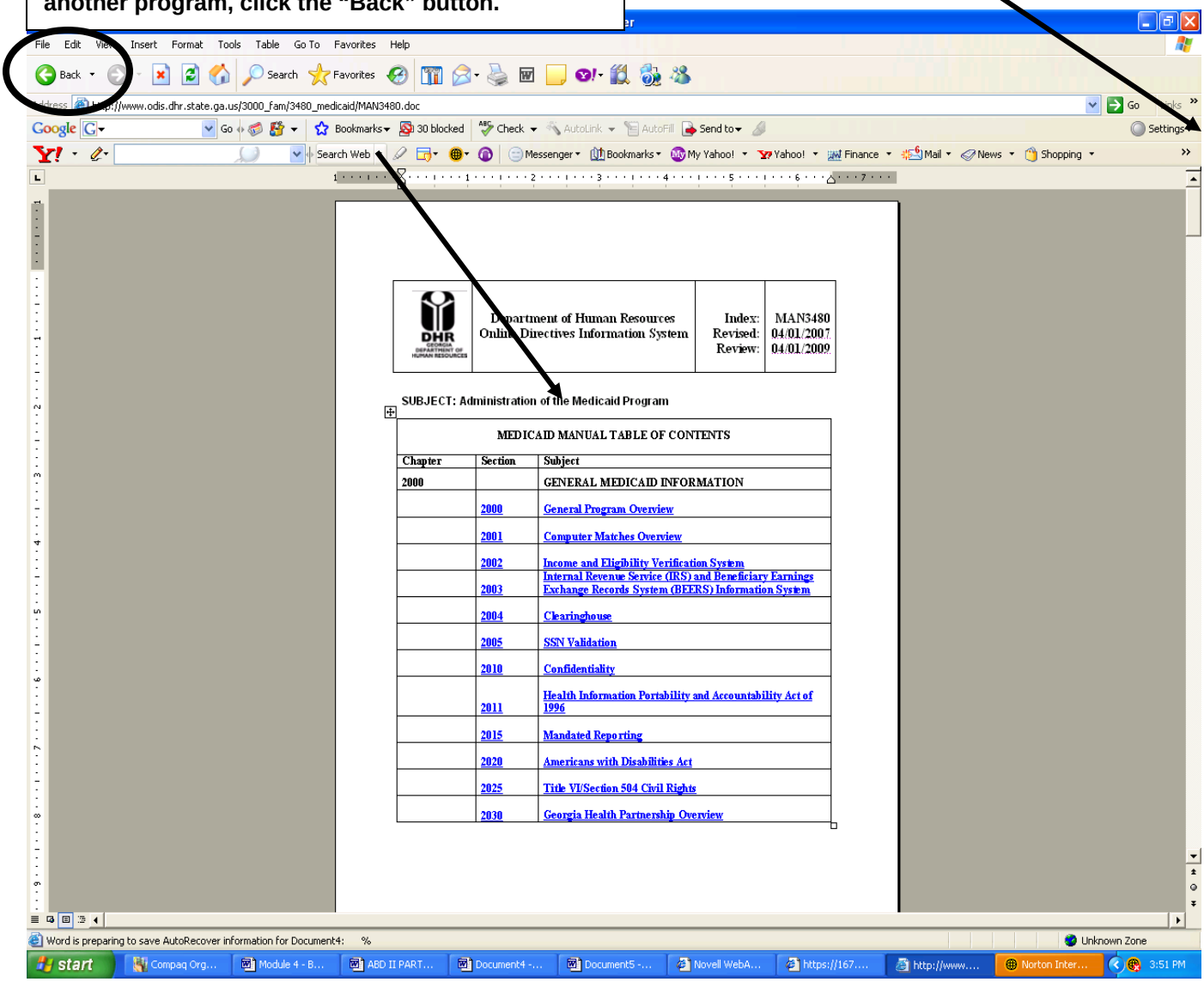
Step 5: Select MAN 3480 and click once

If asked whether you want to 'open' or 'save' the file, always select 'open'.



<u>Step 6:</u> Scroll to the section of the policy manual you want to review, then click on it. Once you have clicked on the policy section, use the scroll bar to move up and down.

To return to the Table of Contents or the Family and Children Directives Sub-Index to choose another program, click the "Back" button.

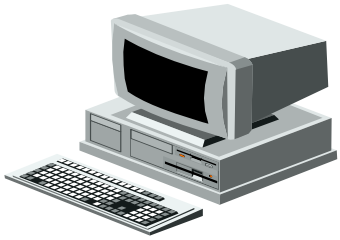


ODIS Scavenger Hunt

Using ODIS, please provide the sections and page numbers for each item below:

1. Mandatory Forms for ABD Medicaid Application Processing
   _____
2. Three sources for verifying disability _____
3. Different types of Income not included in determining financial eligibility _____
4. Policy statement for ISM _____
5. Deeming Resources for LA-D _____
6. Basic Considerations for Q-Track _____
7. Whose Bills Can Be Used for AMN _____
8. Payment Termination Date for Nursing Home_____
9. Protection of Income Chart _____
10. Burial Exclusions for:
    - A) Burial Funds _____
    - B) Burial Contracts_____
    - C) Life Insurance _____

SUCCESS Production Region Security



- **Each employee will be issued his or her own User ID and RACF ID to use to access the SUCCESS system. Please review the "SUCCESS Security" e-mail issued by the Division Director on 5/2/2002.** Review the following page**.**

- Employees who are assigned a SUCCESS USER ID and RACF ID that permits authorization of benefits are legally responsible for all benefits that are authorized under that assigned User ID and RACF ID.

- There are two critical absolutes: (1.) User IDs and RACF IDs are NEVER to be shared or revealed to anyone other than the person to whom it is assigned. (2.) NEVER leave your workstation while signed-on to SUCCESS.

Training RACF IDs and Passwords

CAUTION

During this training you will be issued a RACF ID and a Password. These RACF IDs and Passwords can be used only in the training region. The number of RACF IDs available for participants in the training region is very limited. You must be extremely careful when signing-on to SUCCESS, because **three unsuccessful attempts to sign–on, will revoke your RACF ID.** If you make a mistake twice while attempting to sign-on, sign off completely and go back to the "GO" screen, then start over.

Date: Thursday, 2 May 2002 11:25am ET
To: FIELDDIRECTORS, DFCS.COUNTY.DIRS, SUCCESS.SUPVS
From: DFCS.DIVISION@GOMAIL
Subject: SUCCESS security

Recent events in one of our urban counties have illustrated the need for Division staff at all levels to be cognizant of correct security procedures for SUCCESS user IDs and RACFs. Staff assigned a SUCCESS user ID and RACF which permits authorization of benefits on SUCCESS are legally responsible for all benefits authorized using the assigned ID and RACF. Forms 283 AND 291, completed by all staff to acquire SUCCESS IDs and RACFs, note that the individual is "personally responsible for all actions taken by your UserID/password." IDs and RACFs are never to be shared or revealed to anyone other than the person to whom they are assigned. It is also critical that any person with SUCCESS access never leave her/his workstation while signed on to SUCCESS. Any entry made while signed on is attributed to the person to whom the ID/RACF is assigned, regardless of who may have actually completed the data entry. These security measures are necessary to prevent erroneous benefits from being authorized, case actions being processed in error or invalid cases being established.

It is incumbent upon all management staff at both the Field Area and County levels to insure that correct SUCCESS security procedures are observed in county departments. Every county must insure that terminals are never left unattended while signed on to SUCCESS, to prevent unauthorized issuance of benefits. Counties must also insure that when staff terminate or transfer to other areas that correct security procedures are observed. Field Coordinators will be adding discussions of increased SUCCESS security procedures to their meetings with county directors.
It is my expectation that all counties will review SUCCESS security procedures in every office on a regular basis, and will assure that procedures are in place to prevent unauthorized issuance of benefits on SUCCESS.
----------(end of letter)----------

About the Training Region

The SUCCESS system used in the training region is a good simulation of the county SUCCESS system with only a few differences. In the training region we will not be able to view Clearinghouse.

The System Limitation

In the training region the date is always **10 – 05 – 06.** Therefore, some examples, which include initial application processing, interim changes, and reviews will use **10 – 05 – 06**.

During this training session, you may encounter computer technical problems. As problems occur, we will work together to solve problems. DO NOT try to solve problems on your own. Please notify trainers immediately when problems occur.

Working ahead of the trainers can cause major problems for you, other participants, and the trainers. Working ahead may cause you to miss important information about the system and its process. Therefore, we ask that you remember the UGA/DFCS Classroom rules and follow the SUCCESS Training Golden Rule:

Stay with the Group!
DO NOT work ahead

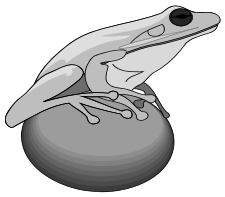


CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1/QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$99,540 + 2000 = $101,540.00	1-06

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$603	$904	1-06
	B	$402	$603	
	C	$603	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1809	$3618	1-06
QDWI	A	$3352	$4485	3-06 Note: Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	C	$3352	N/A	
	D	$3352	N/A	
QMB	A	$817	$1100	4-06
SLMB	A	$980	$1320	4-06
QI-1	A	$1103	$1485	3-06

2006 CHART FOR USE IN SUCCESS TRAINING

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION		
Averaging Nursing Home Private Pay Billing Rate	$4257.60	4-06

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD				
Income Limit	**PMV for an Individual**	**PMV for a Couple**	**Living Allowance**	**Effective Date**
AMN	$221	$321.34	$301.34	1-06
FBR	$221	$321.34	$301.34	1-06
QMB	N/A	N/A	$373..33	4-06
SLMB	N/A	N/A	$446.67	4-06
QI-1	N/A	N/A	$501.67	3-06

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY		
Category	**Income Limit**	**Effective Date**
Non-Blind individuals	$860	1-06
Blind individuals	$1450	

CHART A1.6 – BREAK-EVEN POINTS					
Living Arrangement	**Earned Income**		**Unearned Income**		**Effective Date**
	Individual	**Couple**	**Individual**	**Couple**	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT		
Level of Care	**Monthly Amount**	**Effective Date**
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

2006 CHART FOR USE IN SUCCESS TRAINING

A1.8 – MEDICARE EXPENSES
Medicare Part B Premium rate: $88.50 (effective 1-06).
Medicare Approved Drug Discount Card: up to $30 (effective 6/04)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT		
IF the LA-D Recipient is	**THEN use the following as the PNA in the Patient Liability/Cost Share Budget:**	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents **NOTE:** The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in MRWP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET		
Diversion Standard	**Amount**	**Effective Date**
Community Spouse Maintenance Need Standard	$2488.50	1-06
Dependent Family Member Need Standard	$1670	4-06

2006 CHART FOR USE IN SUCCESS TRAINING

SUCCESS Participant Guide

Customer Service

Objectives

- ☐ Participants will identify Customer Service Behavioral Standards.
- ☐ Participants will discuss personal experiences with customer service.
- ☐ Participants will identify non-verbal communications used in the SOFTEN formula.
- ☐ Participants will review the ten rules for providing quality customer service.
- ☐ Participants will demonstrate the standard DHR telephone greeting.
- ☐ Participants will identify techniques to improve telephone customer service.

Outline

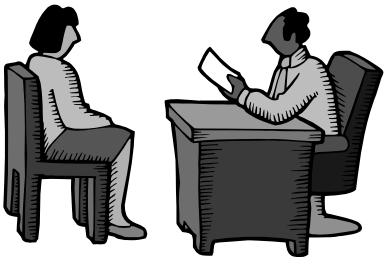
I. Customer Service Behavioral Standards

II. Telephone Interviews

CUSTOMER SERVICE BEHAVIORAL STANDARDS

GREET your customers promptly and courteously.

LISTEN and verify your understanding of the customer's needs.



HELP customers with your answers and actions.

HONOR your commitments in a timely manner.

Experiencing Customer Service Exercise

Think about the experiences you have had in your own life as a customer during the past few months in any place such as a store, restaurant, etc.

Examples of Bad Service:

a) What did the person(s) do, or not do, that made it so awful or disappointing? Please be specific.

b) What should they have done differently?

c) How can we use this in our own work?

Examples of Good/Excellent Service:

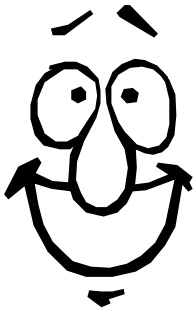
a) What did the person(s) do, or not do, that made the service so exceptional? Please be specific.

b) How can we use this in our own work?

Non-Verbal Communication in Customer Service

Use the **S**-**O**-**F**-**T**-**E**-**N** formula:

Smile:



Open space: Don't put anything between you and the other person.

Forward lean: Sends the message that you care about what the person has to say.

Territory: Do not invade the other person's space.

Eye contact: Make eye contact as often as possible, particularly when speaking to another person.

Nod: Nodding occasionally conveys to the other person that you are listening and interested in what they have to say.

Adapted from PML ASSOCIATES, Inc.
Human Resource/Management Consulting
Greenwood, SC

Ten Rules for Providing Quality Customer Service

1) Greet the Customer Immediately

- Call the customer by a courtesy title (Mr., Mrs., Ms.) and use his or her last name
- Make immediate eye contact
- If you are busy, acknowledge the customer's presence with a nod or a smile
- An immediate greeting only takes a second, but it puts the customer at ease and gets you started on the right foot

2) Give the Customer Your Undivided Attention

- Let the customer know that his or her situation is your number one priority at that time
- Don't act disinterested or bored
- Pay attention to the customer and show that you consider him or her to be important
- Don't try to handle two customers at one time
- Practice good listening skills so you can discuss key points, answer questions, and make appropriate referrals

3) Make the First 30 Seconds Count

- The first 30 seconds belong to the customer, not to you
- Don't force customers into the same mold; recognize that each individual and situation is unique
- Give each customer a chance to communicate his or her needs clearly in the first 30 seconds

4) Be Natural, Not Phony or Mechanical

- Don't give the customer the standard or routine answers to questions
- Express genuine interest and concern
- Avoid the "have-a-nice-day-next" attitude

5) Be Energetic and Cordial

- Approach each contact with a customer as a new event
- When answering the telephone, keep in mind that the customer can't see you and your voice is the only means you have of making a good impression
- Pace yourself as you work

6) Be the Customer's Agent

- Make the commitment to help solve the customer's problem
- Know who is responsible for various duties within your organization so you can make appropriate referrals
- Be willing to apologize to a customer if the situation calls for it – even if you are not the one who made the mistake
- Think of your job as a matter of solving problems for the customer, not just performing a set of tasks

7) Think! Use Your Common Sense

- It's okay to think for yourself
- If the answer isn't "in the manual", stop and think things over
- Try to think beyond the limits of habit, tradition, and standard procedures
- Look for new ways to do things that will be beneficial to your customers

8) Be Flexible

- Don't allow the rules or procedures to become a barrier to helping the customer
- If you are in doubt, check with your supervisor about a new way to solve a customer's problem

9) Make the Last 30 Seconds Count

- The last impression a customer leaves with is just as important as the first impression
- Remember that we are here to serve our customers
- Offer a bit of helpful information; let the customer know what to expect, and what information is needed
- Make the contact a positive experience

10) Take Good Care of Yourself

- You can take good care of your customers by taking good care of yourself
- Everyone has a bad day now and then, but the key to your success is to keep those feelings in check and not let those feelings impact the quality of service you provide
- Pay attention to your feelings throughout the day and keep yourself in a positive frame of mind
- When you are feeling good, you transmit that energy and optimism to your customers as well as to your co-workers

Tips for Positive Telephone Interviews

Smile before answering the phone

Sit up straight

Speak at a comprehensive rate

Use moderate volume

Change voice pitch and inflection

Maintain a clear tone

Creating a Positive Telephone Impression

Conducting Telephone Interviews

DO…

- Prepare for the call
- Identify yourself to the customer
- Tell the customer why you are calling
- Ask for the individual with whom you would like to speak using their formal name
- Listen and paraphrase back
- Make notes during the call
- Ask permission before placing someone on speaker phone
- Summarize the call
- Ask for additional questions and if additional assistance is needed before ending the call

DO NOT…

- Have loud noises in the background
- Eat food or chew gum
- Use DFCS jargon
- Put the phone down/hang up the phone hard

Standard DHR telephone greeting:

Hello _____ (state your Division or office name), this is_____(your name), may I help you?

Example: "Hello, Clarke County Department of Family and Children Services, this is Darren Chester, may I help you?"

Write down how you will answer the phone in your office:

Telephone Techniques:

- The telephone should be answered by the second ring.
- Put a smile on your face when talking. That smile will be "heard" by the caller.
- Adjust your rate of speech to match the caller.
- If you must put someone on hold, ask, "May I place you on hold while I get that information for you?" Make sure you wait for their answer before pressing the button.
- Never keep someone holding for more than 30 seconds. If necessary pick back up and explain any delay and give the caller an opportunity to hang up and have you call them back.

SUCCESS Participant Guide

Screening and Registration

Objectives

After completing this module, the participant will be able to:

- ✓ sign on to the SUCCESS system.
- ✓ identify the basic features of SUCCESS.
- ✓ troubleshoot SUCCESS-related issues
- ✓ distinguish between required and optional fields.
- ✓ identify the names and order of screens in registration.
- ✓ sign off the SUCCESS system.

Given a case study, the participant will be able to:

- ✓ screen an applicant in SUCCESS for current or prior participation in public assistance programs.
- ✓ register an application in SUCCESS.
- ✓ print an application.
- ✓ schedule an intake appointment.
- ✓ enter Authorized Representative data.
- ✓ use SUCCESS support tools.

Outline

I. Introduction

II. Key SUCCESS Concepts

III. SUCCESS Screening

IV. Mary Ellen Smith – CRS Name Inquiry

V. SUCCESS Registration

VI. Mary Ellen Smith – Registration

VII. AU ID Inquiry

VIII. Thomas Hong – NH Case Screening & Registration

IX. Mary Harvey – CCSP Case Screening & Registration

X. Marvin Franklin – Hospice Case Screening & Registration

XI. Review

XII. Signing off SUCCESS

SUCCESS Sign-On Procedures

```
        GGGGGGGGGGGGGGGGGGG            OOOOOOOOOOOOOOOOOOOO
       GGGGGGGGGGGGGGGGGGGGG          OOOOOOOOOOOOOOOOOOOOO
      GGGG             GGGG          OOOO              OOOO
     GGGG             GGGG           OOOO              OOOO
    GGGG    GEORGIA                  OOOO    ONLINE    OOOO
   GGGG                              OOOO              OOOO
  GGGG        GGGGGGGGGG            OOOO              OOOO
 GGGG        GGGGGGGGGG            OOOO              OOOO
GGGG               GGGG           OOOO              OOOO
GGGGGGGGGGGGGGGGGGGGG              OOOOOOOOOOOOOOOOOOOO
GGGGGGGGGGGGGGGGGGGG               OOOOOOOOOOOOOOOOOOO

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```

The first screen that displays is the **“GO”** screen.

On the **“GO”** screen, **type “CICSV2”** and **press enter**.

Note: In the county you will type “DHR8” to access SUCCESS.

The next screen that displays is the SUCCESS sign-on screen.

```
                 Welcome to the Division of Family and Children Services
                              Integrated Systems Sign On Menu

OP   System    Description
 1   CRS       (Client Registration System)
 2   $TARS     (Support, Tracking, Accounting and Reporting System)
 3   EBT       (Electronic Benefits Transfer System)
 4   SUCCESS   (System Uniform Calculation Consolidation Economic Support Services)
 5   SUCCINQ   (Success Statewide Inquiry)
 6   SUCCSTAT  (Success Status Messages)
 7   PSDS      (Protective Services Data System)
 8   EAPS      (Energy Assistance Program)
 9   CCRS      (Child Care Reporting System)
10   DIS/MIS   (Miscellaneous & Disaster Check System)

Please enter your selection: _____
      RACF ID: ___________    PASSWORD:___________    NEW PASSWORD:
Please type in UserId, Password and Option           OR       Press PF3 to Log Off
```

On the SUCCESS sign-on screen, type your Training RACF ID and your Training Password.

SUCCESS TRAINING RACF ID: _____

SUCCESS TRAINING Password: _____

Note: In the Production Region, this menu has two additional options that are not available in the Training Region: Job Information System (JIS) and Debt Setoff System (DSO).

Main Menu

```
                    ************************************
                  **    W E L C O M E   T O   T H E    **
                ***         G  E  O  R  G  I  A         ***
               ***            T R A I N I N G            ***
                ***         S  U  C  C  E  S  S         ***
                  **         S  Y  S  T  E  M          **
                    ************************************


                             Selection  A
                            Printer ID  ????
                           System Date  10-05-06
                               Load ID  1895


    A. Assistance Unit/Client    H. Security             O. File Inquiry
    B. Supporting Units          I. Parameters           P. Vendor Files
    C. PEACH                     J. Mass Mod             Q. Text
    D. Alerts                    K. Financial Mgmt Iss   R. Benefit Error
    E. Scheduling                L. Lifetime Limit       S. AU/Client Misc
    F. Letters                   M. Benefit History
    G. Electronic Mail (EMC2)    N. Quality Control      U. Register IV-D Case

 Message 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

The SUCCESS Main Menu has several options you can choose. Most often your selection will be the Assistance Unit/Client menu. **On this screen you will need to enter your Printer ID number**.

NOTE: Your Training Caseload ID number is also listed on this screen.

SUCCESS Training Caseload ID number here: _____

Assistance Unit/Client Sub-Menu

AMEN

```
                  ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                 AMEN

                                 Selection
                AU ID                          Client ID
             Screen ID                        As Of Date
 Benefit Month (MM YY)                       Notice Type


 A. Name/Part Inquiry      J. Registration          R. Interim/Hist Change
 B. AU/Client Inquiry      K. Add A Person          S. QRF Change
 D. Address Inquiry        L. Add A Program         Y. Spndwn Med Expnse Update
 E. Trial Budget           M. Reinstatement         Z. Spndwn Med Expnse Inquiry
 F. Trial Eligibility      N. Initiate Review       1. Spndwn Authorization
 G. Batch Print Request    O. Interview             5. Prior Medicaid Copy
 H. Notice History         P. Process Appl Months   6. Finalize Prior Medicaid
 I. SPA Inquiry            Q. Finalize Application


 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

The Assistance Unit/Client sub-menu (AMEN) is the starting point for many of the functions completed as a case manager.

Let's answer these questions:

1. What menu option would you choose to complete an initial interview?

2. What menu option would you choose to register an application?

3. What menu option would you choose when a client reports a change?

Case Function

Screen Name

Caseload Number & Date

Screen ID

Client Pointer

```
CHANGE                    HOUSEHOLD ADDRESSES - ADDR                    ADDR 01
Month 11 06                     1001   10 05 06

CO 047 LO 047 Load ID 1001  Client ID 7653005896  Prev CO/LO
HOH F Name ANN        MI     M.  L Name YOUNG             Suf

Auth   Prim    Voter   Visually    Hearing     Public Hsng/  Serial   Census
Rep    Lang     Reg    Impaired    Impaired    Rent Subsidy  Number   Tract
N      E        ?        N           N             N
Residential Address
Address Line 1                         Line 2
Street  Number  Dir          Name           Type    City Dir      Apt
        1515        CHESTNUT                   ROAD
City Atlanta                  ST GA   Zip 30303        Phone 404 312 3443

Mailing Address   Del
Address Line 1                         Line 2
Street  Number  Dir          Name           Type    City Dir      Apt
                          P.O. BOX 521
City Atlanta                  ST GA   Zip 30303
                                        Previous Addresses in last 2 years N
Message 1881      1881
1881 STREET NUMBER OR BOX NUMBER NOT FOUND ON STREET
              15-lett                                 21-narr  23-alau  24-del
```

Field Content

Field Names

PF Function

Warning Message

SUCCESS Screen Layout

Screen Colors

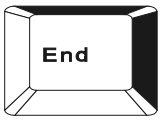
Yellow – Screen and Field Names
Blue – Data that cannot be changed
Green – Data that can be changed
White – Warning Messages
Red Question Marks – Mandatory Fields

Navigating Through SUCCESS

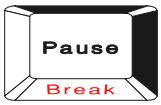
Using the Keyboard

Let's look at several keys that are very important when using SUCCESS.

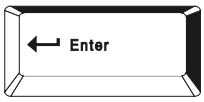
Use the "Delete" key to delete information in a field one character at a time.



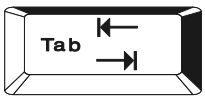
Use the "End" key to delete ALL the information in a field. It is better to use the "End" key, as sometimes the "Delete" key does not totally delete information.



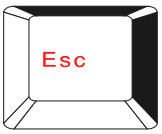
Use the "Pause" key to clear the screen.



Use the "Enter" key next to the letter keypad. DO NOT use the "enter" key next to the number pad.



Use the "Tab" key to move field to field. The "Shift" key plus the "Tab" key (pressing both at the same time) will allow you to move back to the previous field.



Use the "Esc" key to reset the screen when a appears in the bottom left hand corner of the screen and a bell tone sounds. This means a mistake has been made or a command is not recognized by the system.

One way to navigate through SUCCESS is by using the Function Keys. The Function Keys are located across the top of the keyboard.

F1 through F12 have set functions that are the same for ALL screens.

F13 through F24 have specific functions available only if the function appears at the bottom of the screen.

Let's complete the SUCCESS Template

SUCCESS Template for Standard PC Keyboard

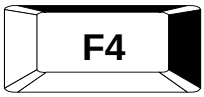
1	2	3	4
13	14	15	16

5	6	7	8
17	18	19	20

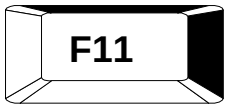
9	10	11	12
21	22	23	24

Helpful Hints for SUCCESS

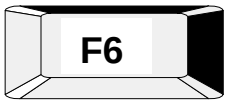
Moving Past NAME/ADDR

In the training region, and sometimes in the production region, you will be unable to move past the **NAME/ADDR** screen by just pressing the "enter" key. This is because in the training region the **NAME/ADDR** screen cannot interface with the Code-1 Plus System to verify the address. **<u>In order to move from NAME/ADDR to the next screen, remember to press</u>** 

The Fast Path Process in SUCCESS

Before you can Fast Path in SUCCESS, you must first know the A/R's line number and the screen name abbreviation. To find the A/R's line number, press 

which will display the list of clients in the AU.

To find the screen name abbreviation, press 

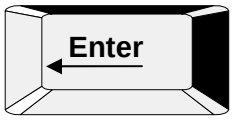
which will display a list of all the screen names and their abbreviations.

HOW TO FAST PATH!!

<u>Step 1</u> Press

to take the cursor to the top right hand corner of the screen.

<u>Step 2</u> Type in the screen name abbreviation and the A/R's line number. Example: If you want to Fast Path to Demographic Screen 2 for Jim who is on line 3, you would type DEM2 03.

<u>Step 3</u> Press 

SUCCESS: The Scratch Pad

If you are in the middle of a case and you need to STOP, simply put your case on the SPA and return to it later. The SPA is the holding area for your case. SUCCESS will store the case for you until you are ready. To SAVE the data to the SPA:

***Press**

*Wait for message "**Press PF5 to hold"**

***Press**

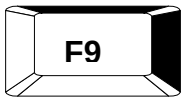
again

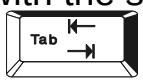
*The AMEN screen will display the message
"SPA successfully put on hold"

Documentation & Text Wrap

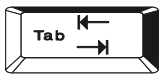
Press the Tilde key

to access screen-specific Automated Documentation Tools (ADTs) to enter the minimum required documentation. ADTs are accessible behind specific SUCCESS screens to capture the minimum documentation required by policy. To move from field to field within the ADT, press the Tilde key

Press 

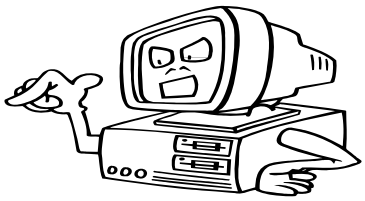
to enter remarks/documentation behind any screen on SUCCESS. Beginning with the second line of the documentation, press the Tab key 

twice, then begin typing.

At the end of each text line, press 

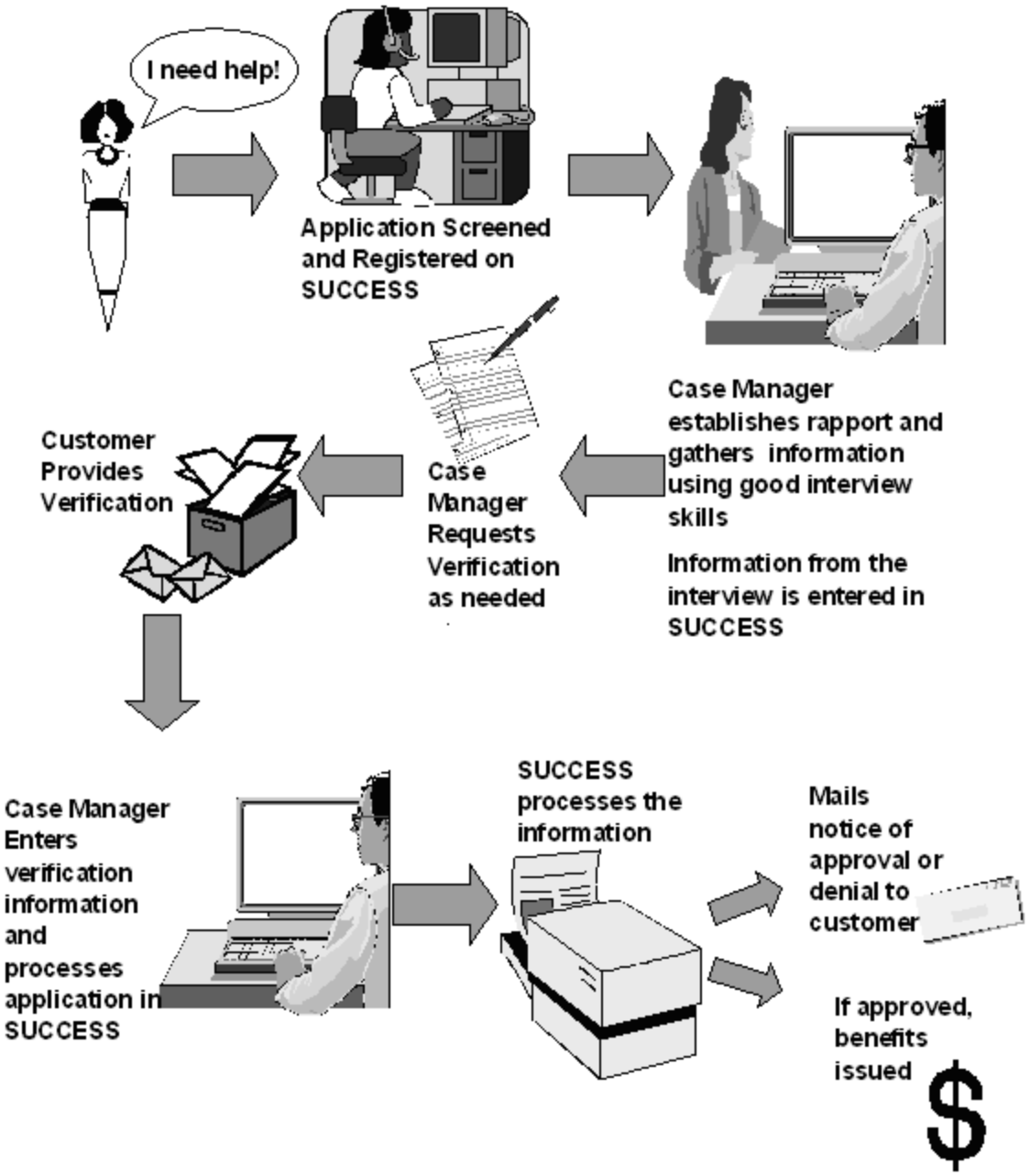
to move to the next line. Only press **"Enter"** when all documentation is completed and you want to return to the SUCCESS Screen.

Trouble Shooting



I'm unable to move forward from ADDR.	Did you press F4 ?
I've entered my RACF twice, but it will not work.	F3 Back to the GO screen and start over, also check your RACF.
I'm unable to move to the next screen.	Check the bottom left corner of the screen, if a displays press Esc
I'm having trouble using the Fast Path steps.	Check the A/R's line number and the screen name abbreviation, then review the Fast Path Steps.
I'm on the DONE screen, but I cannot commit the data.	Did you confirm by typing a "Y" on all "ELIG" and "MAFI" screens?
I'm on the ERRO screen, how do I resolve the errors.	Type the code in the "Display Error Text" field, then Fast Path to correct.

OVERVIEW OF THE APPLICATION PROCESS



Your Role in Registration

Registration is the first step in the intake process.

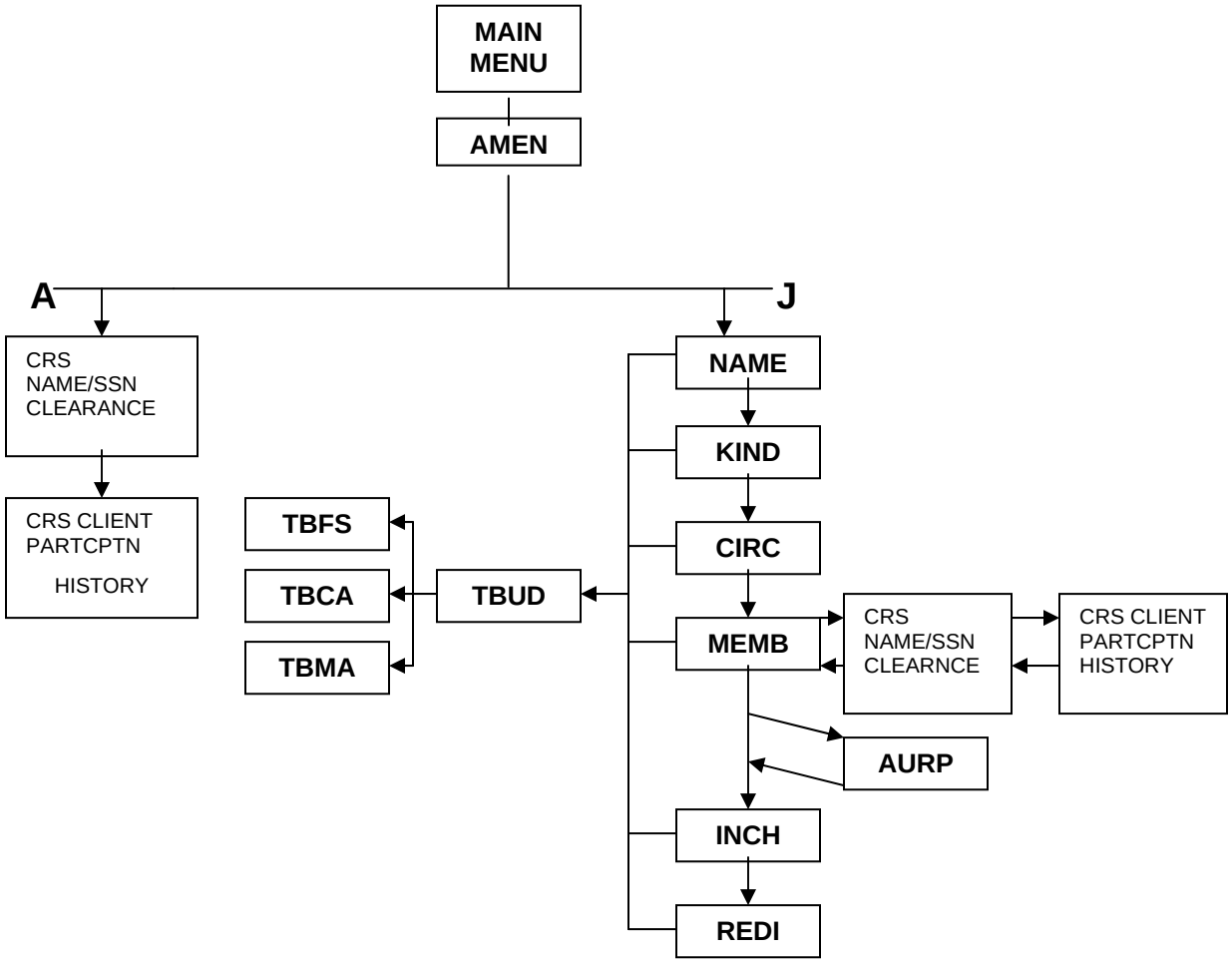
The purpose of registration is to:

- Screen the applicant to see if he or she is an active or former participant
- Collect information from the applicant and enter it on SUCCESS
- Determine programs for which an applicant might be eligible

You may also:

- Schedule an intake interview
- Withdraw an application
- Add text to a notice
- Add comments to the record
- Perform a trial budget

Screen Flow Diagram for Registration from Main Menu:



Procedure: SUCCESS Screening Instructions	
Step	**Procedure**
Scenario: An applicant, known or unknown to the agency, submits an application for services. An applicant is applying to add a NEW person, known or unknown to the agency, to the AU for new or existing services. When interviewing the applicant, always ask if they have ever applied for or received benefits or services.	
Step 1	From the AMEN screen enter option 'A' Name/Part Inquiry. The Client Registration System Name/SSN Inquiry screen will appear.
Step 2	Type in the SSN. Press <Enter>. If the client has used other SSNs, also screen on the other numbers.
Step 3	Then type in the Head of Household's (HOH) information that the applicant provided - **Last name, First Name, Sex ('U' for unknown can also be used).** Press <Enter>. If the client has used other names, also screen on the other name(s).
Step 4	Repeat steps 2 and 3 for each person listed in the household.
Step 5	**If there is one match**, check to ensure the information provided on the application is the same as the data in CRS. Screen print and/or document if all data does not match the client's application.
Step 6	Next, type a 'Y' to the left of the matching client ID and press F11. Screen print and/or document the Client Participation History screen that is displayed for that client ID. Check to see if the client has any active SUCCESS cases.
Step 7	**If there is more than one match,** determine which client ID is correct. For details on this process, please refer to the Instructions for Requesting a Client ID Correction on the next page. The same information is also included in DFCS Systems County Letter #00-100 dated August 18, 2000. When you have determined which ID is correct, type a 'Y' beside the client ID and press F11. Screen print and/or document the Client Participation History screen that is displayed for that client ID. Repeat this process for each client ID shown. Check for any active SUCCESS cases.
Step 8	**If there is a "No Matches Found" message** in the bottom left corner of the screen, there was no match in CRS and the customer must be assigned a new client ID. You cannot assign a new client ID during this inquiry process. In application registration, you would use F8 to move to the last page of the Client Registration System NAME/SSN Clearance screen and then type 'Y' on Assign New Client ID field and press <Enter>.

Mary Ellen Smith

Background: Ms. Mary Ellen Smith is a 73-year-old widow. She has a heart condition that has confined her to the bed. Ms. Smith is not able to care for herself, so her daughter, Gwen Brown, placed her in Oak Manor Nursing Home on 10-3-06.

Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)
   _____
   _____
   _____
   ATTN: _____

APPLICATION RECEIVED
10/04/06

3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial) Smith, Mary Ellen	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial) Brown, Gwen
Mailing Address	
Street Address 2010 Warm Springs Rd	Mailing Address 252 Lake Street
City Columbus State GA Zip 31904 Do you own/are you purchasing home? ☑ Y ☐ N	City Pearson State GA Zip 31513
Phone 706-324-0387 County Muscogee E-Mail Address	Phone 912-342-9658 E-Mail Address
Nursing Facility (if applicable) Oak Manor NH	Relationship to Individual Daughter

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Mary Ellen Maiden/other name(s):	Birthdate 7/10/33	Sex F	Race W	U.S. Citizen (Yes or No) Yes	Social Security Number 200-01-XXXX	Marital Status W
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? ☐ **Yes** ☐ **No**

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

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

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

DHR 700 (R. 02/09)

HEALTH INSURANCE:

Do you have Medicare?	Type of Coverage	Effective Date:	Have you ever received SSI?
☑ Yes ☐ No Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ Yes ☑ No	☑ Part A (hospital) ☑ Part B (doctor) Part D (RX)	7/1998 Medicare Number: 200-01-XXXXA	☐ Yes ☑ No If so, when did it end?
Does your spouse have Medicare? ☐ Yes ☐ No	☐ Part A ☐ Part B Part D	Effective Date: Medicare Number:	Has your spouse ever received SSI? ☐ Yes ☐ No If so, when did it end?

Do you have other health insurance? ☐ Yes ☑ No

Does your spouse have other health insurance? ☐ Yes ☐ No

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live? ☐ Yes ☑ No

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☐ Yes ☑ No If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed

DHR 700 (R. 02/09)

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	☑ Yes	☐ No	Funeral plans/ prepaid burial item	☐ Yes	☑ No
Savings account	☐ Yes	☑ No	Burial plots or contracts	☐ Yes	☑ No
Government bonds	☐ Yes	☑ No	Stocks and bonds	☐ Yes	☑ No
Trust funds	☐ Yes	☑ No	Other (IRA, CD, promissory note, etc.)	☐ Yes	☑ No

Have you or your spouse given away any assets for less than its value? ☐ Yes ☑ No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
Checking	458796-852	$250	Nations Bank

Do you or your spouse have a life insurance policy? ☑ Yes ☐ No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
Mary Ellen	Prudential	37925157	$5000	$270

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security	SSI	Wages/ Self-Employment
Railroad Retirement Benefits	Veterans' Benefits	Trust or Annuity Payments
Pensions/ Retirement Benefits	Rental Income Paid to You	Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
Mary Ellen	RSDI	Social Security	$1340	Monthly	20001 XXXXA

Are you a veteran? ☐ Yes ☑ No Is your spouse a veteran? Yes ✓ No

Where did you and spouse work in the past? alot of different places

Do you or your spouse have any unpaid medical bills ? ☐ Yes ☑ No

DHR 700 (R. 02/09)

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 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: Reven Brown	**Date:** 10/3/04
Signature of Applicant's Spouse or Representative:	**Date:**

DHR 700 (R. 02/09)

DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the Unit States Department of Homeland Security (DHS) of my/my children's citizenship or alien 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	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)

(check whichever applies)

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

_____ SIGNATURE (PARENT/GUARDIAN) _____ (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth(city,state,country)	U.S. Citizen	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)
Mary Ellen Smith	Augusta, GA, US	✓		

(check whichever applies)

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

Mary Ellen Smith
SIGNATURE (PARENT/GUARDIAN) 10/3/06 (DATE)

_____ SIGNATURE (PARENT/GUARDIAN) _____ (DATE)

DHR 700 (R. 02/09)

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY: Oak Manor Nursing Home

CITY: Columbus

MEDICAID PROVIDER NO.: 000083047A

SOCIAL SECURITY NO.: 200 01 XXXX

RECIPIENT'S NAME: Mary Ellen Smith

RECIPIENT'S MEDICAID NO.:

PRIMARY ICD-9-CM: 401.9

SECONDARY ICD-9-CM: 331

DATE OF BIRTH (M M D D Y Y): 07 10 33

SECTION II - ADMISSION

LEVEL OF CARE: 1 (1-Skilled, 2-IC, 3-IC/MR)

PATIENT ADMITTED FROM: D (A-Hospital, B-Nursing Facility (NF), C-State Instit., D-Own Home, E-Other_____, F-SNF Medicare)

ADMISSION DATE (M M D D Y Y): 10 03 06

VA AID & ATTENDANCE INCLUDED: ( )Yes $ _____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME:

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE: 1-Skilled, 2-IC, 3-IC/MR

LOC EFFECTIVE DATE: M M D D Y Y

VA AID & ATTENDANCE INCLUDED: ( )Yes $ _____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME:

SECTION IV - TERMINATIONS

REASON: E-INELIGIBLE, F-DISCHARGED, G-DIED

EFFECTIVE DATE: M M D D Y Y

DISCHARGE DESTINATION: A-Home with a Health Plan, B-Hospital, C-Nursing Facility (NF), D-Other_____, E-Own Home, F-SNF Medicare, L-Limited Stay Expired

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator: X Francis Potter

DATE (M M D D Y Y): 10 03 06

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker: X _____

County Code

DATE (M M D D Y Y):

DMA 59

Mary Ellen Smith – Screen an applicant

Your assignment: Using the data from Ms. Smith's application, screen the A/R to determine if she is known to the system.

Throughout this *Participant Guide,* the data you enter appears in bold type. A narrative explanation for each data element you enter is listed above each screen.

AMEN

- Enter A in the selection field
- Press ENTER

```
                         ASSISTANCE UNIT/CLIENT SUBMENU - AMEN           AMEN

                              Selection A
                 AU ID                          Client ID
              Screen ID                        As Of Date
Benefit Month (MM YY)                       Notice Type



A. Name/Part Inquiry      J. Registration          R. Interim/Hist Change
B. AU/Client Inquiry      K. Add A Person          S. QRF Change
D. Address Inquiry        L. Add A Program         Y. Spndwn Med Expnse Update
E. Trial Budget           M. Reinstatement         Z. Spndwn Med Expnse Inquiry
F. Trial Eligibility      N. Initiate Review       1. Spndwn Authorization
G. Batch Print Request    O. Interview             5. Prior Medicaid Copy
H. Notice History         P. Process Appl Months   6. Finalize Prior Medicaid
I. SPA Inquiry            Q. Finalize Application


Message
```

CRS Name/SSN Inquiry for Mary Ellen Smith

- Enter Ms. Smith's SSN 200-01-XXXX
- Press ENTER (there should not be a match)
- PF2 to refresh screen

```
HRRS0010                CLIENT REGISTRATION SYSTEM      CICSV2       05/09/2007
                              NAME/SSN INQUIRY                        11:13:19
L NAME                      F NAME                M NAME              SFX
SSN1 200 01 XXXX    DOB (MM DD YYYY)            +/-        SEX          MORE

  RACE (Y/N)?: BLACK OR AFRICAN AMERICAN         WHITE         ASIAN
  NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER     AMERICAN INDIAN/ALASKAN NATIVE
  ETHNICITY (L/N)?: HISPANIC/LATINO
SEL CL ID   E CTY L NAME               F NAME        MI  DOB   SX RCE   SSN   A




F1-HELP  F2-REFSH  F3-EXIT  F7-UP  F8-DOWN  F9-CLT DET  F11-CLT PART  F12-RETN
```

- Enter A/R's full name and sex:
  - Mary Ellen Smith
  - U
- Press ENTER (there should not be a match)
- PF2 refresh screen

```
HRRS0010                CLIENT REGISTRATION SYSTEM      CICSV2       05/09/2007
                              NAME/SSN INQUIRY                        11:13:19
L NAME Smith              F NAME Mary        M NAME Ellen             SFX
SSN1                DOB (MM DD YYYY)            +/-        SEX U        MORE

  RACE (Y/N)?: BLACK OR AFRICAN AMERICAN         WHITE         ASIAN
  NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER     AMERICAN INDIAN/ALASKAN NATIVE
  ETHNICITY (L/N)?: HISPANIC/LATINO
SEL CL ID   E CTY L NAME               F NAME        MI  DOB   SX RCE   SSN   A







F1-HELP  F2-REFSH  F3-EXIT  F7-UP  F8-DOWN  F9-CLT DET  F11-CLT PART  F12-RETN
```

Mary Ellen Smith – Register the Application

You've screened Ms. Smith and determined that she doesn't exist in SUCCESS.

Your Assignment: Register Mary Ellen Smith's application. Use the screens and data that follow. The trainer will walk you through the Registration process.

AMEN

- Select J
- Press ENTER

```
           ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                 AMEN

                              Selection J
                AU ID                        Client ID
             Screen ID                      As Of Date
 Benefit Month (MM YY)                     Notice Type



 A. Name/Part Inquiry     J. Registration          R. Interim/Hist Change
 B. AU/Client Inquiry     K. Add A Person          S. QRF Change
 D. Address Inquiry       L. Add A Program         Y. Spndwn Med Expnse Update
 E. Trial Budget          M. Reinstatement         Z. Spndwn Med Expnse Inquiry
 F. Trial Eligibility     N. Initiate Review       1. Spndwn Authorization
 G. Batch Print Request   O. Interview             5. Prior Medicaid Copy
 H. Notice History        P. Process Appl Months   6. Finalize Prior Medicaid
 I. SPA Inquiry           Q. Finalize Application


 Message
```

NAME

- Mary Ellen Smith
- Does not live in public housing
- Does not want to register to vote
- Lives at Oak Manor NH 2010 Warmsprings Rd., Columbus, GA 31904, phone number 706-324-0387
- Press ENTER
- PF4 around warning message

```
REGISTER               APPLICANT NAME AND ADDRESS - NAME            NAME

 CO 044 LO 049 Load ID 1800       Client ID           Prev CO/LO     /
 HOH F Name Mary          MI E   L Name Smith                 Suf

  Primary   Visually    Hearing     Public     Serial    Census    Voter
  Language  Impaired    Impaired    Housing    Number    Tract     Reg
     E         N           N           Z                            N

 Residential Address
 Address Line 1 Oak Manor NH             Line 2
 Street  Number  Dir          Name           Type   City Dir     Apt
         2010           Warmsprings          Rd
 City COLUMBUS                  ST GA   Zip 31904        Phone 706 324 0387

 Mailing Address
 Address Line 1                          Line 2
 Street  Number  Dir          Name           Type   City Dir     Apt
                      SAME
 City                           ST      Zip

 Message 1884
 1884 STREET NAME NOT FOUND IN ZIP CODE AREA
                                         18-tbud
```

KIND

- Select ABD Medicaid
- Press ENTER

```
REGISTER              KINDS OF ASSISTANCE DESIRED - KIND             KIND



                      Select kinds of assistance desired

                         Financial Assistance
                         Food Stamp Assistance
                         AFDC Related Medicaid
                      Y  Medicaid for the Aged, Blind, Disabled (ABD)
                         Foster Care or Adoption Assistance Medicaid
                         Other




 Message


                                          18-tbud
```

CIRC

- Ms. Smith pays a Medicare Premium
- Ms. Smith resides in a Nursing Home
- Ms. Smith has an Authorized Representative
- Press ENTER

```
REGISTER                HOUSEHOLD CIRCUMSTANCES - CIRC              CIRC

 Monthly Income (FS)
   Earnings Types/Amts
   Unearned Types/Amts


 Liquid Resources (FS)
   Resource Types/Amts


 Current Rent/Mortgage/Utilities (FS)

 Select:
   Anyone > 18 who formerly recvd SSI    Any Unpaid Medical Bills Prior Month
 Y Medicare Entitlement                  Community-Based Waiver
 Y Nursing Home                          Hospital
                                         Resident Battered Woman Shelter
   Migrant/Seasonal Farmworker           Refugee
   MA needed for adult with dep child  Y Authorized Rep

 Message

                                         18-tbud
```

MEMB for Mary Ellen Smith

- DOB is 07/10/1933, statement accepted
- She is a female
- She has a SSN of 200-01-XXXX, statement accepted
- She is white
- Press ENTER

```
REGISTER                    HOUSEHOLD MEMBER - MEMB                  MEMB 01
                                                                       01
 Client ID                Del

 F Name MARY           MI E   L Name SMITH                 Suf
 Relationship SE   DOB (MM DD YYYY) 07 10 1933   V CS   Sex F
 SSA/SSN Appl For     SSN1 200 01 XXXX   V CS   Race: B W A N P  Ethnic:  N
 Preg      Due Date                                   N Y N N N

 Alternate Names       F Name    MI        L Name        Suf




                                                          More Names
                              Additional SSNs
       SSN     V           SSN     V           SSN     V           SSN     V

                                                           More SSNs

                                                         More Members
 Message 2026
 2026 NEW OR EXISTING CLIENT (NOT PF3) MUST BE SELECTED IN CRS TO CONTINUE.
                                        18-tbud                        24-del
```

CRS Name/SSN Clearance

- SUCCESS finds no exact match for Mary Ellen Smith
- Enter a Y to assign a new client ID number
- Press ENTER

```
HRRS0010                CLIENT REGISTRATION SYSTEM      CICSV2       05/09/2007
                             NAME/SSN CLEARANCE                       15:59:54

CLIENT ID L NAME               F NAME          MI    DOB     SEX      SSN
000000001 SMITH                MARY            E  07 10 1933  F     200 01 XXXX
RACE (Y/N)?: BLACK OR AFRICAN AMERICAN Y       WHITE  N      ASIAN  N
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER N   AMERICAN INDIAN/ALASKAN NATIVE  N
ETHNICITY (L/N)?: HISPANIC/LATINO N
    0000 POSSIBLE MATCHES                TYPE OF MATCH  NO POSSIBLE MATCHES
 SEL CL ID   E CTY L NAME              F NAME        MI   DOB SEX RCE SSN   ALT



ASSIGN IV-A CLIENT ID
ASSIGN NEW CLIENT ID   Y                      NEXT MATCH TYPE
99010 Required fields must be entered
F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB for Mary Ellen Smith

- SUCCESS has assigned a client ID # for Ms. Smith
- Press ENTER

```
REGISTER                    HOUSEHOLD MEMBER - MEMB                  MEMB 01
                                                                       01
 Client ID 106594364               Del

 F Name MARY           MI E   L Name SMITH                Suf
 Relationship SE   DOB (MM DD YYYY) 07 10 1933   V CS   Sex F
 SSA/SSN Appl For     SSN1 200 01 XXXX   V CS   Race: B W A N P  Ethnic:  N
 Preg      Due Date                                   Y N N N N

 Alternate Names       F Name    MI        L Name        Suf




                                                              More Names
                              Additional SSNs
       SSN     V           SSN     V           SSN     V           SSN     V

                                                              More SSNs

                                                            More Members
 Message 2026
 2026 NEW OR EXISTING CLIENT (NOT PF3) MUST BE SELECTED IN CRS TO CONTINUE.
                                         18-tbud                        24-del
```

Authorized Representative AURP

- Ms. Smith has an authorized representative, use VV **R1** for Rep Type
- Enter Relationship **OR**
- Enter Gwen Brown's name, address and phone number
- Press ENTER

```
REGISTER              AUTHORIZED REPRESENTATIVE - AURP              AURP
                                                                      01

 HOH Name MARY         E SMITH                 Client ID 106594364

 Rep Type R1   Relationship OR   Del
 F Name Gwen           MI     L Name Brown
 Address Line 1 252 Lake St              Line 2/Apt
 City Pearson          ST GA   Zip 31513        Phone 912 532 3460

 Rep Type      Relationship      Del
 F Name                MI     L Name
 Address Line 1                          Line 2/Apt
 City                   ST      Zip              Phone

 Rep Type      Relationship      Del
 F Name                MI     L Name
 Address Line 1                          Line 2/Apt
 City                   ST      Zip              Phone

                                                                    More
 Message

                                         18-tbud                 24-del
```

INCH

- Enter Y in the IND field to select ABD Medicaid
- Application date is 10/04/06
- PF20 to print AFA

```
REGISTER                    INFORMED CHOICE - INCH                   INCH


HOH Name MARY         E SMITH                  Client ID 106594364
           Indicate/add all programs the head of household wishes to apply for

             Ind        Program             Med COA            AU ID
              Y      MA                       L01
                     MA                       W01
              Y      MA                       Q01






              TANF 2P Able Bodied     All FS Applicants receive AF, RF, SSI

                                      Appl Date 10 04 06

           Message

                                                  18-tbud         20-afa
```

REDI

- An appointment will be scheduled for her telephone interview
- Enter the appointment date and time
- Enter the last name and a note about the purpose of the interview
- Press ENTER

```
REGISTER              REGISTRATION DISPOSITION - REDI              REDI


 HOH Name MARY         E SMITH                  Client ID 920000000


                                Withdrawal?


 Sched Interview
                  Unit Type 01                          Unit Supv 0989
               Inquiry Date 10 05 06                      Load ID 1800
                  Appt Date 10 09 06                    Appt Type INT
     Appt Begin Time (HH:MM)  09:00          Appt End Time (HH:MM)  10:00
     L Name/Appt Remarks  Smith/Phone Interview
     Appointment Letter Print Location

         Other Persons At This Address/Other Narrative Information



 Message 0164
 0164 DO YOU NEED TO SCHEDULE AN APPOINTMENT?
  13-note 14-schs 15-nmiq         18-tbud
```

Registration Informed Choice

Program	Choice	Conditions
Food Stamps	Expedited	▪ Migrant/seasonal farm worker and total resources less than or equal to expedited limit ▪ Total income and resources are less than total shelter ▪ Total income and total resources less than expedited limits
Cash Assistance	Refugee (R01)	▪ Financial and refugee
	TANF	▪ Financial, client pregnant and due date is less than current date + 45 days ▪ Financial, AU size greater than one, and non-HOH client is less than 18 years old
AFDC Related Medicaid	Low Income Medicaid (F01)	▪ AFDC Related MA selected, financial, AU size greater than one and one non-HOH client is less than 18 years old
	IV-E Foster Care (F11)	▪ Foster care or adoption assistance (regardless of other selections)
	IV-E Adoption Assistance (F13)	▪ Foster care or adoption assistance (regardless of other selections)
	RSM Child (F22)	▪ Cash not selected and any client less than 19 years old (regardless of pregnancy)
	RSM Pregnant Woman (P01)	▪ Client pregnant (regardless of whether cash is already selected)
	Refugee MA (R03)	▪ Cash not selected and refugee (regardless of pregnancy)
ABD Medicaid	Nursing Home (L01)	▪ Nursing home
	Hospital (L02)	▪ Hospital
	QMB (Q01)	▪ Medicare entitlement
	Pickle (S03)	▪ Anyone over age 18 with prior SSI
	SSI MA (S10)	▪ Any upaid medical bills in prior month
	Medically Needy De Facto (S99)	▪ Hospital
	Waiver (W01)	▪ Home community-based waiver

Background: Thomas Hong is entering a Nursing Home. He will be leaving his wife, Polly, in their home.

Thomas Hong

Thomas Hong Partial Support Case

- Review Mr. Hong's application for ABD Medicaid.
- Additional information: Mr. Hong does not live in public housing and he does not wish to register to vote.
- Begin the screening and registration process for Mr. Hong. Be sure you customize his social security number. Do not select Medicare entitlement.
- After you have assigned a client ID to Mr. Hong, stop at the MEMB screen.
- Appointment time is scheduled for 10-9-06 10:00 A.M. – 11:00 A.M.
- The trainer will walk you through adding Ms. Hong to the registration.

Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)

APPLICATION RECEIVED
10/03/06

ATTN: _____

3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial) Hong, Thomas	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial) Hong, Polly
Mailing Address	
Street Address 145 W. Cleveland St	Mailing Address 785 Harris St. SW
City Nahunta State GA Zip 31553 Do you own/are you purchasing home? ☑ Y ☐ N	City Richland State GA Zip 30265
Phone 478-988-1294 County Brantley E-Mail Address	Phone 770-523-6987 E-Mail Address
Nursing Facility (if applicable) Bayview NH	Relationship to Individual Wife

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Thomas Maiden/other name(s):	Birthdate 4/9/20	Sex M	Race Asian	U.S. Citizen (Yes or No) Yes	Social Security Number 999-99-XXXX	Marital Status M
Name (Spouse): Polly Maiden/other name(s): Hing	8/7/32	F	"	Yes	888-88-XXXX	M

Are you applying for your spouse, too? ☐ **Yes** ☑ **No**

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

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

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

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HEALTH INSURANCE:

Do you have Medicare?	Type of Coverage	Effective Date:	Have you ever received SSI?
☑ Yes ☐ No Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ Yes ☑ No	☑ Part A (hospital) ☑ Part B (doctor) Part D (RX)	4/1985 Medicare Number: 999-99-XXXA	☐ Yes ☑ No If so, when did it end?
Does your spouse have Medicare? ☑ Yes ☐ No	Type of Coverage ☑ Part A ☑ Part B Part D	Effective Date: 8/1997 Medicare Number: 888-88-XXXA	Has your spouse ever received SSI? ☐ Yes ☑ No If so, when did it end?

Do you have other health insurance? ☐ Yes ☑ No

Does your spouse have other health insurance? ☐ Yes ☑ No

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live? ☐ Yes ☑ No

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☐ Yes ☐ No If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed
Car	95	Toyota	Corolla	?	None

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RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	☑ Yes	☐ No	Funeral plans/ prepaid burial item	☐ Yes	☑ No
Savings account	☐ Yes	☑ No	Burial plots or contracts	☐ Yes	☑ No
Government bonds	☐ Yes	☑ No	Stocks and bonds	☐ Yes	☑ No
Trust funds	☐ Yes	☑ No	Other (IRA, CD, promissory note, etc.)	☑ Yes	☐ No

Have you or your spouse given away any assets for less than its value? ☐ Yes ☑ No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
Checking	4578154-88	250	Bank of Georgia
CD	47956821456	5000	Bank of Georgia

Do you or your spouse have a life insurance policy? ☐ Yes ☐ No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
Thomas	Prudential	45789623	19000	None

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security — SSI — Wages/ Self-Employment
Railroad Retirement Benefits — Veterans' Benefits — Trust or Annuity Payments
Pensions/ Retirement Benefits — Rental Income Paid to You — Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
Thomas	RSDI	Social Security	1700	Monthly	999-99-XXXA
Polly	RSDI	Social Security	1400	monthly	888-88-XXXA

Are you a veteran? ☐ Yes ☑ No Is your spouse a veteran? Yes ✓ No

Where did you and spouse work in the past? owned a store, sold it in 1990

Do you or your spouse have any unpaid medical bills ? ☐ Yes ☑ No

DHR 700 (R. 02/09)

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 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: Thomas Hong	**Date:** 9/30/06
Signature of Applicant's Spouse or Representative: Pelly Hong	**Date:** 9/30/06

DHR 700 (R. 02/09)

DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the Unit States Department of Homeland Security (DHS) of my/my children's citizenship or alien 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	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)
		(check whichever applies)		

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

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

ADULT(S) SEEKING BENEFITS

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

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

Thomas Hong
SIGNATURE (PARENT/GUARDIAN)

9/30/06
(DATE)

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

DHR 700 (R. 02/09)

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY: Bayview Nursing Home

CITY: Brantley

MEDICAID PROVIDER NO.: 00062495 1A

SOCIAL SECURITY NO.: 999 99 XXXX

RECIPIENT'S NAME: Hong, Thomas

RECIPIENT'S MEDICAID NO.:

PRIMARY ICD-9-CM: 4019

SECONDARY ICD-9-CM: 331

DATE OF BIRTH: 04 09 20 (M M D D Y Y)

SECTION II - ADMISSION

LEVEL OF CARE: 1 (1-Skilled, 2-IC, 3-IC/MR)

PATIENT ADMITTED FROM: D (A-Hospital, B-Nursing Facility (NF), C-State Instit., D-Own Home, E-Other, F-SNF Medicare)

ADMISSION DATE: 09 30 06 (M M D D Y Y)

VA AID & ATTENDANCE INCLUDED: ( )Yes $ ____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME:

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE: 1-Skilled, 2-IC, 3-IC/MR

LOC EFFECTIVE DATE: M M D D Y Y

VA AID & ATTENDANCE INCLUDED: ( )Yes $ ____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME:

SECTION IV - TERMINATIONS

REASON: E-INELIGIBLE, F-DISCHARGED, G-DIED

EFFECTIVE DATE: M M D D Y Y

DISCHARGE DESTINATION: A-Home with a Health Plan, B-Hospital, C-Nursing Facility (NF), D-Other, E-Own Home, F-SNF Medicare, L-Limited Stay Expired

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator X Francis Peterson

DATE: 09 30 06 (M M D D Y Y)

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X ____

County Code

DATE: M M D D Y Y

DMA 39

Mary Harvey Independent Study Case

- Review Ms. Harvey's application for ABD Medicaid.
- Additional information: Ms. Harvey does not live in public housing and she does not wish to register to vote.
- Screen and register the application; be sure to customize her social security number.
- Appointment is scheduled for 10-9-06 from 11:00 AM to 12:00 PM.
- Ask for assistance, if needed.

Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)
   _____
   _____
   _____
   ATTN: _____

APPLICATION RECEIVED
10/04/06

3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial) Harvey, Mary Mailing Address	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial)
Street Address 994 Hay Street	Mailing Address
City Thomaston State GA Zip 30504 Do you own/are you purchasing home? ☐ Y ☒ N	City State Zip
Phone 706-789-3460 County Upson E-Mail Address	Phone E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Mary Maiden/other name(s):	Birthdate 7/10/24	Sex F	Race B	U.S. Citizen (Yes or No) Yes	Social Security Number aaa-aa-xxxx	Marital Status D
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? ☐ **Yes** ☐ **No**

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

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

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

DHR 700 (R. 02/09)

HEALTH INSURANCE:

Do you have Medicare?	Type of Coverage	Effective Date:	Have you ever received SSI?
☑ Yes ☐ No Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ Yes ☑ No	☑ Part A (hospital) ☑ Part B (doctor) Part D (RX)	7/1989 Medicare Number: 222-22-XXXA	☐ Yes ☑ No If so, when did it end?_____
Does your spouse have Medicare? ☐ Yes ☐ No	Type of Coverage ☐ Part A ☐ Part B Part D	Effective Date: _____ Medicare Number: _____	Has your spouse ever received SSI? ☐ Yes ☐ No If so, when did it end?_____

Do you have other health insurance? ☐ Yes ☑ No

Does your spouse have other health insurance? ☐ Yes ☐ No

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live? ☐ Yes ☑ No

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☐ Yes ☑ No If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed

DHR 700 (R. 02/09)

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	☑ Yes	☐ No	Funeral plans/ prepaid burial item	☐ Yes	☑ No
Savings account	☑ Yes	☐ No	Burial plots or contracts	☐ Yes	☑ No
Government bonds	☐ Yes	☑ No	Stocks and bonds	☐ Yes	☑ No
Trust funds	☐ Yes	☑ No	Other (IRA, CD, promissory note, etc.)	☑ Yes	☐ No

Have you or your spouse given away any assets for less than its value? ☐ Yes ☑ No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
Checking	45879-658	230	First Union
Savings	125478-9652	300	First Union
CD		1000	First Union

Do you or your spouse have a life insurance policy? ☑ Yes ☐ No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
Mary	General American	457984-8652	10,000	Ø

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security — SSI — Wages/ Self-Employment
Railroad Retirement Benefits — Veterans' Benefits — Trust or Annuity Payments
Pensions/ Retirement Benefits — Rental Income Paid to You — Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
Mary	RSDI	Social Security	1230	monthly	222222XXXXA
Mary	VA	VA	900	monthly	232222XXXX

Are you a veteran? ☐ Yes ☑ No Is your spouse a veteran? ✓ Yes No (ex husband)

Where did you and spouse work in the past? _____

Do you or your spouse have any unpaid medical bills ? ☐ Yes ☑ No

DHR 700 (R. 02/09)

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 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: Mary Haney	**Date:** 9/20/04
Signature of Applicant's Spouse or Representative:	**Date:**

DHR 700 (R. 02/09)

DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the Unit States Department of Homeland Security (DHS) of my/my children's citizenship or alien 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	Lawfully Admitted Immigrant (check whichever applies)	Date Naturalized or Admitted into U.S. (If applicable)

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

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

ADULT(S) SEEKING BENEFITS

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

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

Mary Harvey
SIGNATURE (PARENT/GUARDIAN)

9/20/06
(DATE)

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

Georgia Department of Human Resources

COMMUNITY CARE SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section I - A. Identifying Information	2. Patient's Name (Last, First, Middle Initial):
1. CCSP ASSESSMENT TEAM NAME ADDRESS	HARVEY, MARY
	3. Home Address: 994 HAY STREET THOMASTON GA 30504
Telephone:	4 Telephone Number; 5. County: XXXXXXX 6. PSA:

7 Medicaid Number	8. Social Security Number	9. Mother's Maiden Name:
	222-22-XXXX	

10. Sex	11. Age	12 Birthday	13. Race	14. Marital Status	15. Type of Recommendation	16. Referral Source
F	82	7/10/1924	BLACK	DIVORCED	1 xx Initial 2. ☐ Reassessment	

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Resources with necessary information including medical data

17. Signed MARY HARVEY 18. Date 9/9/06

(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation, and Nursing Care Needed	1. ICD	2. ICD	3 ICD
19. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached) 20. Is Patient free of communicable 1. Primary 2 Secondary 3. Other [illegible] 1 D [illegible] 2 D [illegible]			

Medications (including OTC)				Diagnostic and Treatment Pro cedures
21 Name	Dosage	Route	Frequency	22 Type Frequency

23. COMMUNITY CARE SERVICES ORDERED

24 Diet	25 Hours Out of Bed Per Day	26. Overall Cond	27 Restorative Pot	28. Mental and Behavioral Status
Q Regular	Q Intake Q IV	Q Improving	Q Good	Q Agitated Q Noisy Q Dependent
n Diabetic	Q Output Q Bedfast	n Stable	D [illegible]	n Confused n Nonresponsive Q Independent
Q Formula	[] Catheter Care	n Fluctuating	Q Poor	r] Cooperative Q Vacillating Q Anxious
n Low Sodium	Q Colostomy Care	D [illegible] chorating	Q Questionable	Q Depressed Q Violent Q Well Adjusted
n Tube Feeding	n Sterile Dressings	n Critical	Q None	r-] Forgetful Q Wanders Q Disoriented
r] Other	Q Suctioning	n Terminal		n Alert r'] Withdrawn r'] Inappropriate Reaction

29. Decubiti	30, Bowel	31. Bladder	32. Indicate Physical Therapy	Frequency Per We Occupational Therapy	ck Remotive Therapy	Reality Orientation	Speech Therapy	Bowel Bladder Retrain	Activities Program
D [illegible] D [illegible]	Q Continent [*] Occas, Incontinent	Q Continent n Occas Incontinent							
n Infected	Q Incontinent	Q Incontinent							
r*] On Admission	Q Colostomy	Q Catheter							
Q Surgery Date									

33 I Record Appropriate Lege	ind	IMP,	AIR MI	EN TS	i		1. Dependent	AC	TIVITIES OF	DAILY LI\	/ING		
1 Severe													
2 Moderate	Sight	Hear	Spe	sch	Ltd Motion	Para-lysis	2. Needs Asst,	Eats	Wheel-Chair	Trans-fers	Bath	Ambu-lation	Dressing
3. Mild	^	D	D		D	T	3 Independent	T	D	D	D	D	T
4. None							4. Not App						

34 Remarks35- This patient's condition Q could Q could not be managed by provision of n Community Care or n Home Health Services 36, I certify that this patient m requires Q does not require the intermediate leve of care provided by a nursing facility. 37 I certify that the attached plan of care addresses the client's needs for Community Care. 38 Physician's Signature W.E. Barron	39. Physician's Name (Print) W. E. Barron 40. Physician's Address (Print) 15 Cavendar Street, Savannah, GA 32563		
	41. Dale Signed By Physician	42, Physician's Licensure No.	43. Physician's Phone No.

ASSESSMENT TEAM USE ONLY

44. Nursing Facility Level of Care

XX Yes ___ No

46 Signed by person certifying LOC: KATE CARTER

45. L.O.S

Certified Through Date 9/30/07

Date Signed: 9/9/06

Georgia Department of Human Services Resources
COMMUNITY CARE COMMUNICATOR

MARY HARVEY — ANY
CLIENT NAME — COUNTY — PSA NUMBER

994 HAY STREET — 222-22-XXXX
ADDRESS (STREET AND NUMBER) — SOCIAL SECURITY NUMBER — MEDICAID NUMBER

THOMASTON GA 30504 — 7/10/24 — 789-3460
CITY — STATE — ZIP CODE — DATE OF BIRTH — TELEPHONE NUMBER

SECTION I COMPLETED BY CARE COORDINATOR:

I. The client has elected to accept Community Care Services Program: Case Management began effective 9/9/06 and the client was placed in service effective 9/12/06.

☐ The client is currently receiving MAO. Please calculate cost share.
XX The client has been referred for eligibility determination and cost share.
☐ The client will require a home visit for application (Reason in Remarks).

Signature KATE CARTER Telephone No. 452-8695 Date 9/14/06

SECTION II COMPLETED BY DFCS MEDICAID WORKER:

II. ☐ The date client applied for MAO _____

☐ The client has been determined Medicaid eligible effective _____. ☐ The client is receiving Community Care Program Services and is responsible for contributing toward the cost.

☐ The client has a change in cost share.

$ _____ EFFECTIVE _____ $ _____ EFFECTIVE _____ $ _____ EFFECTIVE _____

☐ The client has been determined ineligible, effective _____ (Reason in Remarks).

Signature _____ Telephone No. _____ Date _____

SECTION III COMPLETED BY CARE COORDINATOR:

III. The above named client is being released from the Community Care Services Program effective _____. for the following reason:

☐ Client deceased; Date of Death _____
☐ Condition has improved; services no longer needed.
☐ Condition has worsened; entering a nursing home. Name, if known _____
☐ Other _____

Signature _____ Telephone No. _____ Date _____

SECTION IV COMPLETED BY CARE COORDINATOR or DFCS MEDICAID WORKER:

REMARKS: _____

Form CCC (Rev. 10-29-04

Marvin Franklin Independent Study Case

- Review Mr. Franklin's application for ABD Medicaid; Mr. Franklin has cancer—he was approved for RSDI disability 3/02.
- Additional information: Mr. Franklin does not live in public housing and he does not wish to register to vote.
- Screen and register the application, be sure to customize his social security number.
- Appointment is scheduled for 10-9-06 from 1:00 PM to 2:00 PM.
- Enter Hospice Care Agency as authorized representative.
- Ask for assistance, if needed.

Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)
   _____
   _____
   _____
   ATTN: _____

APPLICATION RECEIVED
09/30/06

3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial) Franklin, Marvin	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial) Franklin, George
Mailing Address	
Street Address 994 Gordon Road	Mailing Address same
City Newnan State GA Zip 30263 Do you own/are you purchasing home? ☑ Y ☐ N	City same State Zip
Phone 770 253 6895 County Coweta E-Mail Address	Phone same E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual SON

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Marvin Maiden/other name(s):	Birthdate 7/23/45	Sex M	Race B	U.S. Citizen (Yes or No) Yes	Social Security Number 55555 XXXX	Marital Status W
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? ☐ **Yes** ☐ **No**

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

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

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

DHR 700 (R. 02/09)

HEALTH INSURANCE:

Do you have Medicare?	Type of Coverage	Effective Date:	Have you ever received SSI?
☑ **Yes** ☐ **No** Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ **Yes** ☑ **No**	☑ **Part A** (hospital) ☑ **Part B** (doctor) **Part D** (RX)	3/2004 Medicare Number:	☐ **Yes** ☑ **No** If so, when did it end?
Does your spouse have Medicare? ☐ **Yes** ☐ **No**	Type of Coverage ☐ **Part A** ☐ **Part B** **Part D**	Effective Date: Medicare Number:	Has your spouse ever received SSI? ☐ **Yes** ☐ **No** If so, when did it end?

Do you have other health insurance? ☐ **Yes** ☑ **No**

Does your spouse have other health insurance? ☐ **Yes** ☐ **No**

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live? ☐ **Yes** ☑ **No**

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☑ **Yes** ☐ **No** If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed
Truck	1993	Ford	F150	?	None

DHR 700 (R. 02/09)

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	☑ Yes	☐ No	Funeral plans/ prepaid burial item	☐ Yes	☑ No
Savings account	☐ Yes	☑ No	Burial plots or contracts	☐ Yes	☑ No
Government bonds	☐ Yes	☑ No	Stocks and bonds	☐ Yes	☑ No
Trust funds	☐ Yes	☑ No	Other (IRA, CD, promissory note, etc.)	☐ Yes	☑ No
Have you or your spouse given away any assets for less than its value?				☐ Yes	☑ No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
Checking	1236547-89	$350	Bank of America

Do you or your spouse have a life insurance policy? ☑ Yes ☐ No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
Marvin	Life of Georgia	7854123-956	$30,000	Ø

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security — SSI — Wages/ Self-Employment
Railroad Retirement Benefits — Veterans' Benefits — Trust or Annuity Payments
Pensions/ Retirement Benefits — Rental Income Paid to You — Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
Marvin	RSDI	Social Security	$1365	monthly	55555XXXA

Are you a veteran? ☐ Yes ☑ No Is your spouse a veteran? Yes No

Where did you and spouse work in the past? Self Employed

Do you or your spouse have any unpaid medical bills ? ☐ Yes ☑ No

DHR 700 (R. 02/09)

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 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: George Franklin	**Date:** 9/28/04
Signature of Applicant's Spouse or Representative:	**Date:**

DHR 700 (R. 02/09)

DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the Unit States Department of Homeland Security (DHS) of my/my children's citizenship or alien 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	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S.
		(check whichever applies)		(If applicable)

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

_____ SIGNATURE (PARENT/GUARDIAN) _____ (DATE)

ADULT(S) SEEKING BENEFITS

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

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

George Franklin SIGNATURE (PARENT/GUARDIAN) 9/28/06 (DATE)

_____ SIGNATURE (PARENT/GUARDIAN) _____ (DATE)

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HOSPICE CARE COMMUNICATOR

TO/FROM: Vista Care (hospice care agency)
(circle one) Our Medicaid provider # is _____

TO/FROM: Coweta (county DFCS office)
(circle one)

RE: Marvin Franklin 994 Gordon Rd. Newnan GA 30263
(patient name) (patient address)
555-55-XXXX 07/23/45
(Social Security number) (Date of birth)

Section I (to be completed by hospice care agency)

{✓} The above-named patient elects to receive hospice care services beginning 9/15/06. The certification period extends from 9/15/06 through 12/13/06.

{ } The above-named patient revokes hospice care or is otherwise discharged from Hospice care effective _____. Destination _____.

{✓} The patient's doctor certified on 9/15/06 that the patient's life expectancy is anticipated to be six months or less.

{ } The patient is admitted to hospice care in a nursing home as of _____

{ } The patient is discharged from hospice care in a nursing home as of _____.

Brenda Harris 9/15/06
(Signature of Director) 1585 Highway 34 East (Date)
Newnan, GA 30265

Section II (to be completed by county DFCS office)

{ } The above named patient has been determined Medicaid eligible effective _____, and the Medicaid ID# is _____.

{ } The above-named has been denied/terminated Medicaid effective _____.

{ } Since this patient is admitted to hospice care in a nursing home, the monthly patient liability amount is $_____, effective _____.

{ } The monthly patient liability amount is changed to $_____, effective _____, and $_____, effective _____.

{ } Other: _____

_____ _____
(Signature of Caseworker) (Date)

Rev. 07/06 **DMA-527**

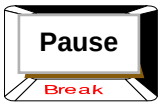
The Game of SUCCESS

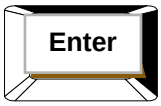
Screens	Colors	Navigation	Resources
100	100	100	100
200	200	200	200
300	300	300	300
400	400	400	400
500	500	500	500
750	750	750	750
1000	1000	1000	1000

SUCCESS Sign-off Procedures

- Press

back to the Main Menu
- Press

again
- Message will read SUCCESS Session Terminated
- Press 

to clear the screen
- Type CESF Logoff
- Press 

SUCCESS Participant Guide

Initial Application

Objectives

Given a case study, the participant will be able to:

√ accurately enter demographic and financial program information to complete an initial application interview in SUCCESS.

√ document initial applications in compliance with documentation standards provided.

√ enter verification information, process application months and finalize an approved or denied initial application in SUCCESS.

√ set up a case record in compliance with case record organization standards provided.

√ use PF keys and fast path to Navigate within SUCCESS.

√ inquire on active and denied cases with AU and/or client data.

√ access historical and ongoing benefit months.

√ complete the CMD process in SUCCESS to trickle to the appropriate benefit type.

√ discuss batch and online processing.

√ process prior months.

√ add or correct missing or incorrect demographic information.

√ approve QMB, Nursing Home, Community-Based Waiver and MN classes of assistance within SUCCESS.

√ save data to SPA

√ troubleshoot and correct errors encountered during the application process.

Outline

I. Introduction

II. Entering Interview Data in SUCCESS

III. Tracey Smith – Q Track Application – “O” Interview - Walk Through

IV. Tracey Smith – Q Track Application – “P” Processing - Walk Through

V. Tracey Smith – Q Track Application – “Q” Finalizing - Walk Through

VI. John Dunne – Review Notice - Walk Through

VII. Jonathan Daniels – Q Track Application - Independent Study

VIII. Thomas Hong – Nursing Home Application – Partial Walk Through

IX. Mary Ellen Smith – Nursing Home Application – Independent Case

X. Mary Harvey – CCSP Application – Partial Walk Through

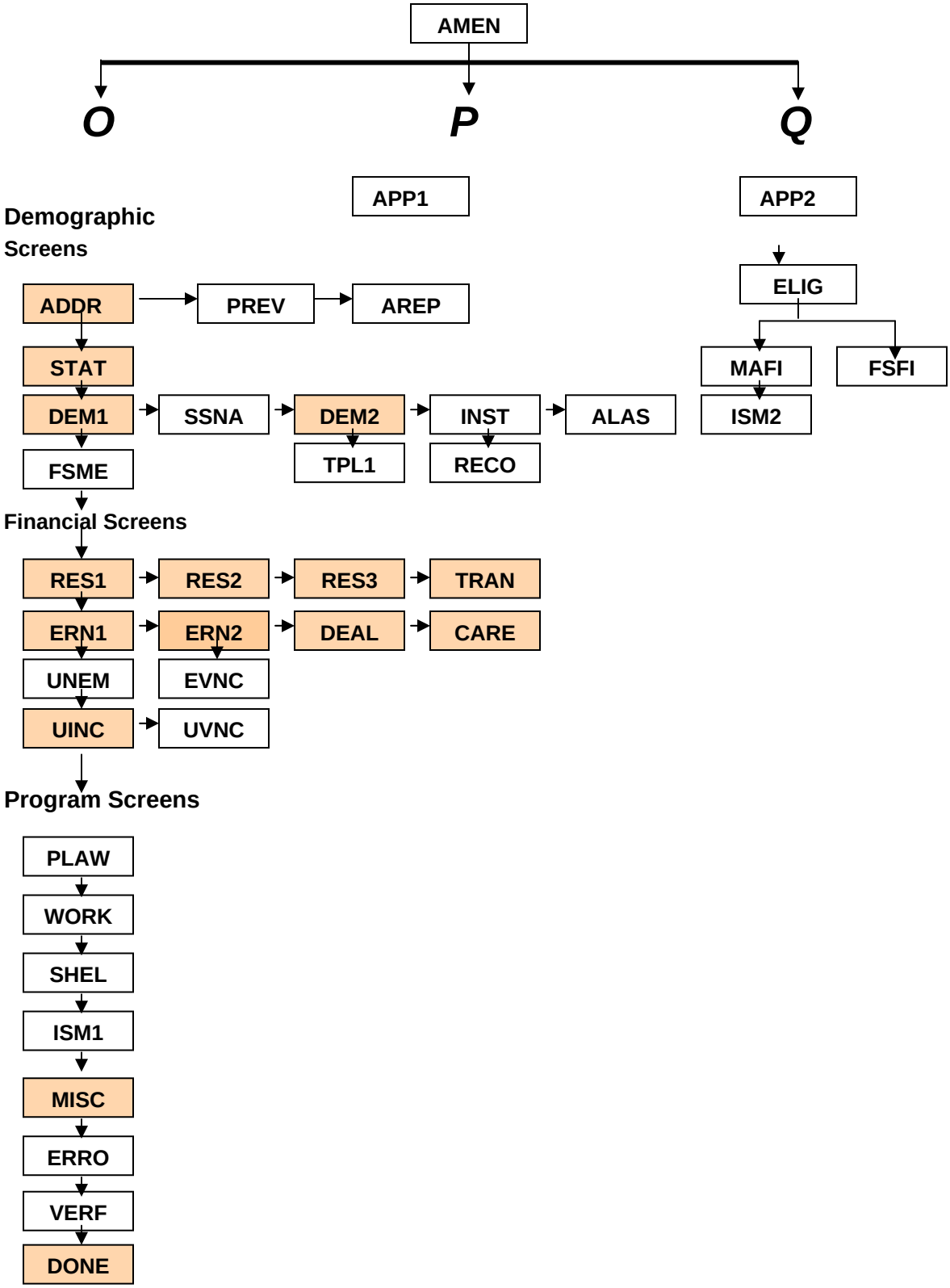
XI. Marvin Franklin – Hospice Application – Partial Walk Through

XII. Assessment Andrea James – O,P,Q

XIII. James Compiano – Medically Needy Application – Partial Walk Through

XIV. James Compiano – Medically Needy Spenddown – Walk Through

Screen Flow Diagram for Functions O, P, and Q from AMEN:



Tracey Smith
Interactive Interview - O

Background: Tracey Smith is a 71-year-old woman, currently residing alone in her own home.

Your Assignment:

- Review Ms. Smith's application.
- Answer the policy questions relating to Ms. Smith.
- Review the verification that is available to you.
- Complete the attached Verification Checklist and review with your trainer.
- Complete the attached Burial Exclusion Form.
- Complete the attached manual budget, Form 172.
- Then complete the initial application process to determine if Ms. Smith is eligible for QMB benefits.

Ms. Smith is a "full support" case. The trainer will go through the screens with you. Please stay with the group during this case.

Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)
   _____
   _____
   _____
   ATTN: _____

APPLICATION RECEIVED 10/02/06
REGISTERED AU ID XXXX00214

3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial) Smith, Tracey	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial)
Mailing Address	
Street Address 135 Rumble Road	Mailing Address
City Macon State GA Zip 31211 Do you own/are you purchasing home? ☑ Y ☐ N	City State Zip
Phone 678-524-0052 County Bibb E-Mail Address	Phone E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Tracey Maiden/other name(s):	Birthdate 8/12/35	Sex F	Race B	U.S. Citizen (Yes or No) Yes	Social Security Number 98501 XXXX	Marital Status S
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? ☐ **Yes** ☐ **No**

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

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

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

DHR 700 (R. 02/09)

HEALTH INSURANCE:

Do you have Medicare? ☑ Yes ☐ No Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ Yes ☑ No	Type of Coverage ☑ Part A (hospital) ☑ Part B (doctor) Part D (RX)	Effective Date: 2/2000 Medicare Number: 98501XXXA	Have you ever received SSI? ☐ Yes ☑ No If so, when did it end?
Does your spouse have Medicare? ☐ Yes ☐ No	Type of Coverage ☐ Part A ☐ Part B Part D	Effective Date: Medicare Number:	Has your spouse ever received SSI? ☐ Yes ☐ No If so, when did it end?

Do you have other health insurance? ☐ Yes ☑ No

Does your spouse have other health insurance? ☐ Yes ☐ No

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live? ☐ Yes ☑ No

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☑ Yes ☐ No If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed
Car	02	Honda	Accord	$7000	Ø

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RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	☑ Yes	☐ No	Funeral plans/ prepaid burial item	☐ Yes	☑ No
Savings account	☐ Yes	☑ No	Burial plots or contracts	☐ Yes	☑ No
Government bonds	☐ Yes	☑ No	Stocks and bonds	☐ Yes	☑ No
Trust funds	☐ Yes	☑ No	Other (IRA, CD, promissory note, etc.)	☐ Yes	☑ No

Have you or your spouse given away any assets for less than its value? ☐ Yes ☑ No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
Checking	0032589743684	$126	First Union

Do you or your spouse have a life insurance policy? ☑ Yes ☐ No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
Tracey	Lincoln Group	89562241-AS	$8000	Ø

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security	SSI	Wages/ Self-Employment
Railroad Retirement Benefits	Veterans' Benefits	Trust or Annuity Payments
Pensions/ Retirement Benefits	Rental Income Paid to You	Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
Tracey	RSDI	Social Security	600	monthly	98501XXXXA
Tracey	Pension	Hilton Hotels	200	monthly	

Are you a veteran? ☐ Yes ☑ No Is your spouse a veteran? Yes No

Where did you and spouse work in the past? Hilton Hotel

Do you or your spouse have any unpaid medical bills ? ☐ Yes ☑ No

DHR 700 (R. 02/09)

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 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: Tracey Smith	**Date:** 9/30/06
Signature of Applicant's Spouse or Representative:	**Date:**

DHR 700 (R. 02/09)

DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the Unit States Department of Homeland Security (DHS) of my/my children's citizenship or alien 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	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)

(check whichever applies)

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

_____ SIGNATURE (PARENT/GUARDIAN) _____ (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth(city,state,country)	U.S. Citizen	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)
Tracey Smith	Warner Robins, GA, US	✓		

(check whichever applies)

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

Tracey Smith SIGNATURE (PARENT/GUARDIAN) 9/30/06 (DATE)

_____ SIGNATURE (PARENT/GUARDIAN) _____ (DATE)

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MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
TRACEY SMITH

MEDICARE CLAIM NUMBER
985-01-XXXXA

SEX
FEMALE

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) 02-2000

MEDICAL INSURANCE (PART B) 02-2000

SIGN HERE ➡ Tracey Smith

POLICY QUESTIONS

- **For what type of Medicaid is the AR applying (remember the CMD order of eligibility)?**
- **What is the SOP for this application?**
- **What type of interview is required?**
- **What mandatory forms must be completed?**
- **How will categorical relationship be verified for this AR?**
- **How will enumeration be verified?**
- **Does the AR need to apply for any other benefits?**
- **What are the AR's countable resources?**
- **How will each resource be verified?**
- **What is the AR's countable income?**
- **How will each type of income be verified?**

COMPLETE THE VERIFICATION CHECKLIST FOR THIS AR.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between _____AM and _____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

BURIAL EXCLUSION
☐FBR or☐ NON-FBR
(Check Which)

Complete form for each A/R & spouse, as needed. Application/Review date: _____

BURIAL CONTRACT:

a. Name of Funeral Home: _____ Phone #: _____

b. Contract owned by A/R or Spouse? ☐ Yes ☐ No If no, who owns: _____

c. Is contract itemized? ☐ Yes ☐ No

d. Is contract designated for A/R or spouse? ☐ Yes ☐ No

e. Is contract paid in full? ☐Yes ☐ No If yes, list purchase price $_____ Date: _____

f. Determine the value of the paid in full burial space items. List below:

Burial Space Item	$ Value
Total	

g. Subtract $ amount in F from $ amount in E.

As of: E - F = Countable non-burial space amt.

Date _____ $ _____ - _____ = $ _____

IF	THEN
Contract owned by other than A/R or Deemor,	Do not count as a resource. Investigate for possible transfer of assets. Section 2342.
Contract owned by A/R/Deemor & is irrevocable,	Treat same as revocable contract.
Contract owned by A/R/Deemor, is Non-itemized, revocable & for family member,	Count as a resource the full "Current Refund Value" of the contract. See above.
Contract owned by A/R/Deemor, is itemized, revocable & paid in full,	Count the "Countable non-burial space amt." shown above.
Contract owned by A/R/Deemor, is itemized, revocable & **NOT** paid in full & is not designated or for non-family member,	Count the refund value of burial space items for those non family members.
Contract Not paid in full,	The burial space items that are **PAID** for may be designated for burial. Any PAID for NON burial space items are a countable resource.

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BURIAL EXCLUSION DOCUMENTATION

BURIAL FUNDS: Attach copy of Form 985. If totally excluded, do not count interest accrued.

LIFE INSURANCE POLICIES: Attach copy of "Record of Life Insurance Policies".

h. From Form 985, enter value of any **Burial Fund(s)**:

Designated Value:	Value + accrued interest (Use only if unable to use for Burial Exclusion allowance.)
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____ Total	$ _____ Total

NOTE: If part of a burial fund is not to be excluded, compute the percentage of the countable portion to use in subsequent reviews. Use the same procedure as in e, f & g of Burial Contracts.

i. From **"Record of Insurance Policies"**, enter Face Value (FV) and Cash Surrender Value (CSV) of each policy. Use CSV only if unable to use for Burial Exclusion allowance.
Documentation:

FV	CSV
$	$
$	$
$	$
$	$
$	$
$	$

Totals:

j. **Burial Assets**
Total of Burial Contracts: (g.) $ _____
Total of Burial Funds: $ _____
Total of FV of Life Insurance: $ _____
Total Burial Assets: $ _____

k. **Burial Exclusion Allowance:** _____
Contracts used for Burial Exc. $ _____
Burial Funds used for Burial Exc.$ _____
FV of Life Ins. used for Bur. Exc. $ _____
Actual amt. designated for Burial $ _____
(Total should be = or < than $1500/$10,000)

l. **Total to count toward resource** limit **of A/R:** (Use **only** if **all** burial assets are not exempt.)
Burial Contract (g): _____
Burial Funds (2nd column h. above) _____
CSV of Life Insurance (i. above): _____
Total countable burial assets: _____

Does this amount combined with other assets exceed the resource limit?
Yes ☐ No ☐

m. Enter the total amount in k. in SUCCESS, RES1, as a "burial contract" (BC) to be excluded. Count those not excluded for burial as a countable resource (l. above). Enter total in l. above in SUCCESS, RES3, as other countable resource (OC), and document case on REMA.
Add text to the notice if A/R's AU is closed/denied due to excess burial assets: "Due to burial policy changes, your resources exceed the allowable limit. Manual reference Sections 2311, 2312, 2323."

DHR 05/09

Georgia Department of Human Resources

ABD Medicaid Individual/Couple/Spouse to Spouse Deeming Budget Sheet

AU Name:_____ AU # _____
Class of Assistance:_____ Living Arrangement: _____ Date:_____

Section A- Individual Calculation: Use to budget a Medicaid Individual OR a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) in LA-A or LA-B. Not for use on Medicaid Cap budgeting.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	
UNEARNED INCOME				
1. Enter A/R's Total GROSS Unearned Income				
2. Subtract $20 General Deduction. (Subtract $0 from IBON)				
3. Net Unearned Income (Line 1 minus Line 2)				
Earned Income (Go to Line 11 if no earned income)				
4. Enter A/R's Total GROSS Earned Income.				
5. Subtract remainder of $20 General Deduction.				
6. Subtotal (Line 4 minus Line 5)				
7. Subtract $65 Earned Income Deduction.				
8. Subtotal (Line 6 minus Line 7)				
9. Subtract ½ of Line 8.				
10. Subtotal (Line 8 minus Line 9)				AMN 3
TOTAL INCOME				Mo BP
11. Total Net Income (Line 3 plus Line 10)				
12. INDIVIDUAL Income Limit (FBR, Q-track, MNIL)				
13. Surplus/Deficit OR 1st Potential AMN Spenddown (Line 11 minus Line 12)				

NOTE: If a surplus exists on Line A.13, **STOP** (the A/R is ineligible) unless AMN. If a deficit exists or the COA is AMN continue.
NOTE: For Q Track eligibility, A/R must be eligible for the COA as an individual (Section A), in order to meet eligibility for the same COA as an individual with an ineligible spouse (Section C(. Example: A/R is SLMB eligible as an individual (Section A) but appears to be QMB eligible under Spouse to Spouse Deeming budget (Section C). A/R will only be eligible for SLMB, since s/he is ineligible for QMB as an individual.

Section B- Deeming From Ineligible Spouse: Use to budget a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) in LA-A or LA-B.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____
UNEARNED INCOME			
1. Enter Ineligible Spouse's GROSS UNEARNED Income (Exclude IBON)			
2. Subtract Living Allowance for Ineligible Child(ren) minus the Child(ren)'s Income			
3. Ineligible Spouse(s)' UNEARNED Income to include in Section C (Line 1 minus Line 2)			
Earned Income			
4. Enter Ineligible Spouse(s)' GROSS EARNED Income.			
5. Subtract any portion of Living Allowance not subtracted from Unearned Income.			
6. Ineligible Spouse(s)' EARNED Income to include in Section C (Line 4 minus Line 5)			

Georgia Department of Human Resources

See REVERSE SIDE for Continuation of Budgeting

AMN Only: If the combined total of Lines B.3 and B.6 does NOT exceed ½ the Individual MNIL, STOP and use the 1st Potential Spenddown from Line A.13 as the AMN Spenddown.

Section C- Spouse-to-Spouse Deeming or Couple Calculation: Use to budget a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) OR a Medicaid Couple in LA-A or LA-B.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	
UNEARNED INCOME				
1. Enter Total GROSS Unearned Income of A/R and Unearned Income deemed from Ineligible Spouse (Line A.1 plus UNEARNED Income from Line B.3) OR Total GROSS Unearned Income of Medicaid Couple.				
2. Subtract $20 General Deduction. (Subtract $0 from IBON)				
3. Net Unearned Income (Line 1 minus Line 2)				
Earned Income (Go to Line 11 if no earned income)				
4. Enter Total GROSS Earned Income of A/R and Earned Income deemed from Ineligible Spouse (Line A.4 plus EARNED Income from Line B.6) OR Total GROSS Earned Income of Medicaid Couple				
5. Subtract remainder of $20 General Deduction.				
6. Subtotal (Line 4 minus Line 5)				
7. Subtract $65 Earned Income Deduction.				
8. Subtotal (Line 6 minus Line 7)				
9. Subtract ½ of Line 8.				
10. Subtotal (Line 8 minus Line 9)				AMN 3 Mo BP
TOTAL INCOME				
11. Total Net Income (Line 3 plus Line 10)				
12. COUPLE Income Limit (FBR, Q-track, MNIL)				
13. Surplus/Deficit OR 2nd Potential AMN Spenddown (Line 11 minus Line 12)				

AMN Only: Use the 1st Potential Spenddown (Line A.13) or 2nd Potential Spenddown (Line C.13), whichever is greater.

NOTE: For Q Track eligibility, A/R must be eligible for the COA as an individual (Section A), in order to meet eligibility for the same COA as an individual with an ineligible spouse (Section C). Example: A/R is SLMB eligible as an individual (Section A) but appears to be QMB eligible under Spouse to Spouse Deeming budget (Section C). A/R will only eligible for SLMB, since s/he is ineligible for QMB as an individual.

Documentation/Computation Space:

Form 172 (R. 01/06)

INTERVIEW

AMEN:

- Select "**O**" from the AMEN Menu
- Enter Ms. Smith's AU ID number
- Press ENTER

```
        ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                 AMEN

                              Selection O
                AU ID XXXXXXXXX              Client ID
            Screen ID                       As Of Date
Benefit Month (MM YY)                      Notice Type



A. Name/Part Inquiry      J. Registration         R. Interim/Hist Change
B. AU/Client Inquiry      K. Add A Person         S. QRF Change
D. Address Inquiry        L. Add A Program        Y. Spndwn Med Expnse Update
E. Trial Budget           M. Reinstatement        Z. Spndwn Med Expnse Inquiry
F. Trial Eligibility      N. Initiate Review      1. Spndwn Authorization
G. Batch Print Request    O. Interview            5. Prior Medicaid Copy
H. Notice History         P. Process Appl Months  6. Finalize Prior Medicaid
I. SPA Inquiry            Q. Finalize Application



Message 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

ADDR:

- Information from Registration is pre-populated
  Ensure Ms. Smith's address was entered correctly at registration
- Enter the Residence County Code in the RES CO field
- PF1 and enter the correct Public Housing Code
- Press PF 21 and document background information about the case on the "Narrative" (NARR) Screen (See Documentation Standards)
- Press PF4 to bypass warning message

```
INTERVIEW                HOUSEHOLD ADDRESSES - ADDR                ADDR 01
  Month 11 06                     0002   10 02 06

 CO 044  LO 049  Load ID 1021  Client ID 180000332  RES CO 011
 HOH F Name TRACEY         MI     L Name SMITH                Suf

 Auth   Prim    Voter   Visually    Hearing     Public Hsng/  Serial   Census
 Rep    Lang     Reg    Impaired    Impaired    Rent Subsidy  Number   Tract
  N      E        N        N           N             Z
 Residential Address
 Address Line 1                        Line 2
 Street  Number  Dir          Name           Type    City Dir      Apt
         135         RUMBLE                RD
 City MACON                  ST GA   Zip 31211        Phone 678 524 0652

 Mailing Address   Del
 Address Line 1                        Line 2
 Street  Number  Dir          Name           Type    City Dir      Apt
                     SAME
 City                        ST      Zip
                                          Previous Addresses in last 2 years N
  Message 0013      1884
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
              15-lett                                21-narr  23-alau  24-del
```

```
UPDATE                NARRATIVE - NARR                NARR
                                                01
 10/04/2006 01:32 PM Ima Worker, 875h, 105, ANY, 478-567-4353
  Initial application Form 700 and Citizenship form for Q-track received
10/2/06.  HIPAA forms mailed to Ms. Smith for signature.



                                                More
MESSAGE

13-bott
```

STAT:

- Ms. Smith's relationship is verified by her statement
- The financial responsibility code is applicant
- Press "tilde" key and document according to documentation standards.
- Press ENTER

```
INTERVIEW                  ASSISTANCE STATUS - STAT                 STAT    A
  Month 11 06                    0002   10 02 06                        01

 AU ID XXXXX0214  Prog MA  Prog Type A  Prev ABD Type     Med COA Q01   Claim N
    CO 044    LO 049    Load ID 1021    Conversion Date

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty----   Appeal
 Stat    Reasons     Date      Date     Date     Date    Type  End Date    Ind
  P                 100206   100206
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T   Date
 TRACEY SMI   SE OT        PN   P 100206      100206






 Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                            20-rmen       22-alau(arch)      23-alau(curr)
```

```
XSGDWH#########################UHPDUNV#0#UHPD#########################UHPD#######
############################################################################34########
###------------------------------#PHGLFDLG#VWDW#-------------------------------###
###4323725339#35=44#SP#LPD#ZRUNHU/#;:8k/#438/#DQ\/#7:;089:07686#######
###OLVW#RWKHU###QDPH##################UHODW########DJH######ILQ#UHV#~\2Q¢########
###KK#PHPEHUV###=bbbbbbbbbbbbbbbbbb###=bbbbbbbbb###=bbbbb###=bbbbbbb###########
###QRW##LQFO########=bbbbbbbbbbbbbbbbbb###=bbbbbbbbb###=bbbbb###=bbbbbbb###########
###LQ#WKH#DX########=bbbbbbbbbbbbbbbbbb###=bbbbbbbbb###=bbbbb###=bbbbbbb###########
###LQHOLJLEOH2SHQDOL]HG#DX#PHPEHUB#\2Q#+Q,#LI#\HV/#H[SODLQ=bbbbbbbbbbbbbbbb######
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###H[SODLQ#VWHS#SDUHQW#VLWXDWLRQ=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###WUDFH#UHODWLRQVKLSV#DQG#GRFXPHQW#ILQDQFLDO#UHVSRQVLELOLW\=###################
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###OLP#HOLJLEOHB#\2Q#+Q,#LI#QR/#H[SODLQ=#QR#FKLOG#XQGHU#DJH#4;#LQ#DXbbbbbbbb######
###FPG/#DV#QHHGHG=bT#WUDFN#EHLQJ#SURFHVVHG1#QR#VVL#RU#XQSDLG#PHG#ELOOVbbbbbbb#
###GXDO#HOLJ#DX#PHPEHU+V,2FRDB#H[SODLQ=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###6PS#FRYHUDJH#UTVWG1B#\2Q+Q,#LI#\HV/#PR1#DQG#GHWHUPLQDWLRQ#IRU#HD1=bbbb#bb######
###=b######
###FURVV#UHI#DX&V#IRU#6PS#DQG#RQJRLQJ=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###H[SODLQ#XVH#RI#833#GHQLDO#FRGH=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
#####################################################################Pruh####
#PHVVDJH#####################################################################
#############################################################################
#460erww#####################################################################
```

DEM1:

- Ms. Smith has never been married
- She lives at home
- She does not receive SSI
- Press PF9 and document using Documentation Standards

```
INTERVIEW                 CLIENT DEMOGRAPHIC 1 - DEM1                DEM1 01
  Month 11 06                     0002   10 02 06

 Client Name TRACEY         SMITH                Suf       Client ID 180000332

 Alt   SSA/SSN   SSN Appl      SSN1     V   More        DOB       V Sex Race Eth
 Name  Appl For    Date                       SSNs    (MM DD YYYY)
                           985 01 1180  CS           02 12 1935   CS  F   B   N


 GA   Marital   Living   RSM  Min Par  Boarder   Amt Paid  -- Family Planning --
 Res  Status    Arrngmt Ad/Ch   /LA    Num Meals for Meals  Referral     Date
  Y     N         AH


  Concurr   SSI   Depriv  V  Prenatal Care   ---------- Pregnant ---------  FTC
 Out of St  Recip            Ind  Good Cse   Term/Due  Term/Due  V  Num V   Code
 CA  FS MA                                    Code      Date        Exp
 N   N  N    N


 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
               15-lett                       16-crs            23-alau
```

```
UPDATE                    REMARKS - REMA                    REMA
                                          01
 10/04/2006 01:55 PM Ima Worker, 875h, 105, ANY, 478-567-4353
  *No previous marriages
  *Over income for SSI

                                                  More
 MESSAGE

 13-bott
```

EXAMPLE OF DEM2 IN THE PRODUCTION REGION (03/08)

```
INTERVIEW          CLIENT DEMOGRAPHIC 2 – DEM2                    DEM2 01
Month 03 08                AUTO   12 31 07
                                                          Remarks
Client Name  TRACEY SMITH                  Client ID  180000332

Citz V  Orig ID Stdnt V Grade V  Striker ---Immunization –     Law –Health Chk-
        Cert    Stat    Comp     Stat       Curr GCse Due Dt    Brkr Ref   Date
 C   SM  Y   Y                     N

TPL TPL   V ------Medicare-----   ------ Disability / Incapacity -----
   Coop    Entitlement Claim Num  Disab  Approval Begin Date  End Date
     C    CS    Y      985011800A Type   Source    (MM YYYY)   (MM YYYY)

Joint  Vet   Military   Death   TANF Cap Parent ----- TANF Cap Child ----
SSI/FS Stat  Serv Num   Date    Ctr End Date  Parnt  ID Rcv Mo Cncpt GCse
        N

Non-Custodial Parent?  V

Message

       15-lett                                          22-tpl 23-alau
```

See ABD SUCCESS Desk Guide for Coding Instructions.

DEM2:

- Ms. Smith is a US Citizen; verified by her receipt of Medicare—the VV of OT will be used
- Agrees to cooperate with TPL based on her statement
- Entitled to Medicare, Medicare Claim Number is 98501XXXXA
- Not a veteran
- Press “tilde” and document using Documentation Standards

```
INTERVIEW                 CLIENT DEMOGRAPHIC 2 - DEM2               DEM2 01
  Month 11 06                     0002   10 02 06

 Client Name TRACEY         SMITH                 Client ID 180000332

 Citiz V  Student V  High Grade V Striker ---Immunization --  Law -Health Chk -
          Stat      Completed     Stat   Curr GCse Due Dt   Brkr Ref   Date
   C   OT                          N

 TPL  TPL   V  ------ Medicare -----    ------  Disability / Incapacity ------
      Coop     Entitlmnt   Claim Num    Disab  Approval Begin Date  End Date
                                        Type   Source   (MM YYYY)   (MM YYYY)
  N    C    CS  Y       985011800A

 Joint  Vet   Military    Death   TANF Cap Parent ------ TANF Cap Child ----
 SSI/FS Stat  Serv Num    Date     Ctr  End Date  Parnt ID Rcv Mo Cncpt GCse
        N

 Non-Custodial Parent?     V


 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
              15-lett                                    22-tpl 23-alau
```

```
XSGDWH##########################UHPDUNV#0#UHPD##########################UHPD#######
#################################################################34########
###------------------#KHDOWK#LQVXUDQFH2FLWL]HQVKLS2LGHQWLW\#------------------###
###4323725339#35=48#SP#LPD#ZRUNHU/#;:8k/#438/#DQ\/#7:;089:07686#######
###GRHV#D2U#KDYH#KHDOWK#LQVXUDQFH#RU#RWKHU#WSO#~WUXVW/H1J1¢B##\2Q#+Q,############
###LI#\HV/#GDWH#IRUP#5;8#VHQW#WR#GPD=bbbbbbbbbbbbbbbbb##########################
###DVVLJQPHQW#RI#WSO#ULJKWV#FRPSOHWHGB#\2Q#+\,#
###VLJQHG#IRUP#GPD#5;8#LQ#WKH#UHFRUGB##\2Q#+Q,Irup#:33#vljqhg##<263239###########
##############################################################################
###FXVWRPHU#ZDV#LQIRUPHG#DERXW#KHDOWK#FKHFN#E\##############################
###IDFH#WR#IDFH+#,#WHOHSKRQH+#,#PDLOHG#EURFKXUH+#,##############################
##############################################################################
###FLWL]HQVKLS#YHULILHG#E\=#UHFHLSW#RI#PHGLFDUHbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###LGHQWLW\#YHULILHG#E\=#######################################################
###=bbbUHFHLSW#RI#PHGLFDUHbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###GHFODUDWLRQ#RI#FLWL]HQVKLS#LQ#UHFRUG#GDWHG=#<263239#
#
###IV#RQO\#0#FLWL]HQVKLS#JRRG#FDXVH#ZDLYHU#JUDQWHG#GXH#WR=bbbbbbbbbbbbbbbbb######
```

RES1:

- Ms. Smith has a checking account at First Union with a balance of $126.00, account number 0032589743-684.
- Ms. Smith has a term life insurance policy with Lincoln Group. The policy has a face value of $8,000.
- Press PF9 and document using Documentation Standards

```
INTERVIEW                    RESOURCES 1 - RES1                    RES1 01
  Month 11 06                                                         01

 Client Name TRACEY         SMITH                 Client ID 180000332

 Do you have any of the following: cash, money loaned out, checking, savings,
 credit union, CD's, stocks, bonds, or secured notes?

 Del Type   Amount   V       Acct Num        Institution Name
     CH    126.00  CS  0032589743-684     First Union




 Do you have any of the following: life insurance, pre-paid burial contracts,
 real estate, or cemetery lots?

 Del Type Face Amt   Cash Amt V    Policy Num        Company Name
     BC   8000.00    ?        CS   89562241-AS       Lincoln Group

                                                                        More
  Message

                 15-lett                                      23-alau   24-del
```

UPDATE REMARKS - REMA REMA
01
10/04/2006 02:07 PM Ima Worker, 875h, 105, ANY, 478-567-4353
Ms. Smith has a term life insurance policy with a face value of $8000, she has No other burial assets. The life insurance is entered as code “BC” per instructions on the Burial Exclusion Form. Data Broker checked and nothing found.
More
MESSAGE
13-bott

RES2:

- Ms. Smith has a 2002 Honda Accord, the value does not matter.
- The type is “motor vehicle”
- It is used for day to day transportation
- Enter the year, make and model
- Also enter the information for Ms. Smith’s homeplace; the value does not matter.
- Press PF9 and document using Documentation Standards
- Press ENTER

```
INTERVIEW                    RESOURCES 2 - RES2                      RES2 01
  Month 11 06                                                           01

 Client Name TRACEY         SMITH                 Client ID 180000332

 Do you have any of the following: truck, motorcycle, tractor, farm equipment,
 licensed/unlicensed vehicle(s), boat, camper, income producing vehicle?

 Del Type  Use       FMV    V  Encumb   V   Yr  Make  Mod  Lic Num Registration
         MA/AF FS
     mv   da         ?     bb             02 Honda Accor
                      VIN

 Do you have any of the following: vacation home, real estate, or rental prop?

 Address 135 RUMBLE RD        City MACON         ST GA     Zip  31211

 Del   Use    FMV    V     Encumb  V     Try     Annl Rate  V   Age Life
                                      to Sell    Ret Amt       Est Own
        HP     ?      CS
                                                                        More
  Message

                 15-lett                                      23-alau   24-del
```

```
UPDATE                    REMARKS - REMA                REMA
                                          01
  10/04/2006 02:21 PM Ima Worker, 875h, 105, ANY, 478-567-4353
  No property search--Q track
  Data Broker checked and homeplace property found.
                                          MESSAGE

 13-bott
```

RES3:

- No data to enter
- Press ENTER

```
INTERVIEW                    RESOURCES 3 - RES3                    RES3 01
 Month 11 06                                                         01

 Client Name TRACEY         SMITH                 Client ID 180000332

 Do you have any of the following: safety deposit box, business holdings, non-
 home consumption produce, livestock, or other valuables?

              ----------------- Other Property ------------------

               Del  Type     FMV   V    Encumb  V   Annl Rate  V
                                                     Return

                                                                   More
 Message

          15-lett                                                 24-del
```

TRAN:

- No data to enter
- Press ENTER

```
INTERVIEW               TRANSFER OF RESOURCES - TRAN                TRAN 01
 Month 11 06                                                         01

 Client Name TRACEY        SMITH                 Client ID 180000332

 Del   Transf  Discovery   Transferee   Resource    FMV      V      Amt       V
 Ind   Date      Date        R'Ship       Type                     Rec'd
      (MM YY)   (MM YY)




 Reason for   Undue Hardship     1st Mth
 Transfer      Ind   Rsn       NH/Wvr MA
                                 (MM YY)

                                                                   More
 Message

           15-lett                                                24-del
```

ERN1:

- No data to enter
- Press ENTER

```
INTERVIEW                    EARNED INCOME 1 – ERN1                    ERN1 01
 Month 11 06                           10 02 06                        01

 Client Name TRACEY          SMITH                 Client ID 180000332

 Do you have any of the following: wages, self employment, commissions/tips,
 roomer/boarder income, rent, mortgage payment, sick pay, work program, JTPA,
 Job Corps, training allowance, use/sale of personal property, or other income?

 Employer Name                                                 AJS Employ
 Line 1                            Line 2
 City                   ST      Zip              Phone
        Begin    First      End     Late   SON    $30+1/3    $30+1/3     $30
 Type   Date    Pay Date    Date    Rpt    Ovrd   Ind Cntr   End Date  End Date
                                         TANF
                                         LIM
                                         RSM
                              Num of  ABD Stdnt  AFDC Student ------JTPA----
                              Bordrs    Excl       Ind Cnt    Ind Cnt   Excl

                                                                More Jobs
 Message
                15-lett
```

ERN2:

- No data to enter
- Press ENTER

```
INTERVIEW                EARNED INCOME 2 - ERN2                      ERN2 01
Month 11 06                                                          01

Client Name TRACEY      SMITH                        Client ID 180000332

Employer Name

              Avg Hrs     Freq          Day Week Pd             Extra Pay

Del

  Amt 1    V   Amt 2     V    Amt 3     V       Amt 4    V        Extra    V

-----------------------------   Work Expenses  --------------------------------
          Type  Amount   Freq    V         Type  Amount   Freq     V

                                                                     More Jobs
Message 0616
0616 GO TO “ERN1” FOR ENTRY OF INITIAL JOB INFORMATION
     15-lett                        16-evnc              23-alau         24-del
```

DEAL:

- No data to enter
- Press ENTER

```
INTERVIEW                    DEEM/ALLOCATE - DEAL                    DEAL 02
 Month 11 06

 Client Name TRACEY         SMITH                 Client ID  180000332

 -------------- Deemor Budget ---------------  ----- CS Paid Outside Home -----
 Num IRS Dep Alimony  V   Other Exp  V         Del  Oblig Amt  V   Paid Amt  V

 ------------- ABD Allocation ---------------
    Inelig                  Inelig
 Del Ind    Amount   V   Del Ind   Amount  V
                                                      Number Of
                                                      ABD Child
                                                      Appl Recip

 -------------- Alien Sponsor --------------- ---------- AF Allocation ------
 Amt Actually Contributed/V                    Client ID
 Number of Other Spons Aliens                  Who can
 Number of Other FS Recips Spons               Allocate to me

 Message
           15-lett                                            24-del
```

CARE:

- No data to enter
- Press ENTER

```
INTERVIEW                       DEPENDENT CARE EXPENSES - CARE              CARE 01
Month      11 06                                                               01

Client Name    TRACEY         SMITH         Client ID  180000332

Provider                                            Phone
Address                 City                                        ST
Zip
                                                                     More providers
Del                  Extra Dependent Expense   Day of Week Pd            Rsn

Depname   Und2   Freq   Date Pd     Amt           Date Pd    Amt          Date Pd
Extra     V






                                         More Dependents For This Provider
Message

                       15-lett                                          24-del
```

UINC:

- Ms. Smith has two sources of unearned income
- The first source of unearned income is a private pension from her previous employer, Hilton Hotels
- Ms. Smith receives $200 per month
- Last received on 10/01/06, verified by her statement
- Press PF9 and document using Documentation Standards
- Enter a Y in the More field to access a second UINC screen

```
INTERVIEW                    UNEARNED INCOME - UINC                    UINC 01
  Month 11 06                                                            00

 Client Name TRACEY         SMITH                 Client ID 4;3333665

 Do you have any of the following: RSDI, alimony, direct child support,
 contributions, VA, workers compensation, unemployment, sick/disability benfits,
 pension, railroad retirement, any other retirement, rent, interest, annuities,
 dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay
  RB             MO

 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V
 10 01 06   200.00    CS


                                 Client Potentially Elig For Other Benefits?
                                                                   More Y
  Appl Type     Stat    Date                 Appl Type     Stat    Date
  Message

               15-lett                        16-uvnc           23-alau  24-del
```

UINC:

- Ms. Smith's other source of unearned income is Social Security
- Enter the type and frequency code
- Enter Ms. Smith's claim number, the number can be found on BENDEX—we will use 98501XXXXA (customize the X's with your load ID)
- Ms. Smith receives $600 per month
- Last received on 10/01/06, verified by BENDEX
- Press PF9 and document using Documentation Standards

```
INTERVIEW                    UNEARNED INCOME - UINC                    UINC 01
  Month 11 06                                                            01

 Client Name TRACEY          SMITH                 Client ID 180000332

 Do you have any of the following: RSDI, alimony, direct child support,
 contributions, VA, workers compensation, unemployment, sick/disability benfits,
 pension, railroad retirement, any other retirement, rent, interest, annuities,
 dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay
 SA             MO    98501XXXXA

 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V
 10 01 06  600.00    BX


                                  Client Potentially Elig For Other Benefits?
                                                                        More
  Appl Type     Stat    Date                 Appl Type     Stat    Date
  Message

               15-lett                        16-uvnc           23-alau  24-del
```

```
UPDATE                    REMARKS - REMA                    REMA
                                   01
  10/04/2006 02:33 PM Ima Worker, 875h, 105, ANY, 478-567-4353
  BENDEX agrees with AR statement about RSDI, CS accepted for verification of
  Retirement amount, Q-track

                                                   More
 MESSAGE

13-bott
```

MISC:

- No data to enter
- Press ENTER

```
INTERVIEW           AU NON-FINANCIAL MISCELLANEOUS - MISC            MISC    A
 Month 11 06                     0097   10  02  06

 HOH Name TRACEY        SMITH                 Client ID 180000332
 AU ID XXXXX0214    Prog MA

Pre    Pre   AU  ATP  ATP  QRF   QRF Pre- Calc Trial Pro Exp SLAM -Extended MA-
Issn   EBT  Issn Prnt Cyc Status Ctr sump Elig  HH   Ovr Svc  Cd  Start Dt  COA
       Card Mode Cnty Num  Code      Elig Ind   Ind                          Cor


 ----- Review ----   Auto   ------- Lump Sum Remainder ------  Delay  QMB   RSM
Compl  Mand  Last  Reasgn  Amount    100 %    133 %    185 %   Rsn   Ovr   Elig
       Std   Type   Ovr                                                    Ovr
                      N
 Sched Interview          QC Penalty End Date
 Del      Unit Number 106502     Inquiry Date 10 02 06       Load ID
      Next Review                   Appt Date               Appt Type
      Appt Begin Time (HH:MM)    :
      Appt End Time (HH:MM)      :           Appt Letter Print Location L
      L Name/Appt Remarks
 Message

 13-note 14-schd 15-lett                         20-schs       23-alau
```

DONE:

- No data to enter
- Press ENTER to commit to database

```
INTERVIEW                    SESSION SUMMARY - DONE                    DONE
Month 11 06                                                              01
                                                                    Narr



  AU ID      Prog   Med COA      Elig      - Status -     -- Benefit --     Outstanding
                                  Req     Code Cfirm    Amt   Cfirm       Verifications
 XXXXX0214          Q01           N         P



Message 0428     0759
0428 PRESS ENTER TO COMMIT
                                        16-prwp     20-edd     21-narr
```

PROCESS APPLICATION MONTHS - P

AMEN:

- Select P
- Press ENTER

```
               ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                AMEN

                            Selection P
                AU ID XXXXX0214          Client ID
            Screen ID                    As Of Date
Benefit Month (MM YY)                    Notice Type


A. Name/Part Inquiry      J. Registration          R. Interim/Hist Change
B. AU/Client Inquiry      K. Add A Person          S. QRF Change
D. Address Inquiry        L. Add A Program         Y. Spndwn Med Expnse Update
E. Trial Budget           M. Reinstatement         Z. Spndwn Med Expnse Inquiry
F. Trial Eligibility      N. Initiate Review       1. Spndwn Authorization
G. Batch Print Request    O. Interview             5. Prior Medicaid Copy
H. Notice History         P. Process Appl Months   6. Finalize Prior Medicaid
I. SPA Inquiry            Q. Finalize Application



Message 0004
0004 THIS IS A NUMERIC FIELD, ONLY NUMBERS MAY BE ENTERED
```

APP1:

- Enter Y in the Select field next to benefit month 10/06
- Press ENTER

```
UPDATE                  PROCESS APPL MONTHS - APP1                  APP1
                                                                      01

 AU ID XXXX0214   Prog MA
 HOH Name TRACEY         SMITH                    Client ID 180000332


           Sel  Bnft   Status   Med COA       Disposition Status
                Month
            Y   10 06    P        Q01      FINAL EDITS NEEDED
                11 06    P        Q01      WAITING FINALIZATION









 Message

  13-amen
```

ADDR:

- No data to enter
- Fastpath to DONE

```
CHANGE                    HOUSEHOLD ADDRESSES - ADDR                DEM2 01
  Month 10 06                     0002   10 05 06

 CO 044  LO 049  Load ID XXXX  Client ID 180000332  RES CO 011
 HOH F Name TRACEY         MI     L Name SMITH                 Suf

 Auth   Prim    Voter   Visually    Hearing     Public Hsng/  Serial   Census
 Rep    Lang     Reg    Impaired    Impaired    Rent Subsidy  Number   Tract
  N      E        N        N           N             Z
 Residential Address
 Address Line 1                         Line 2
 Street  Number  Dir          Name           Type    City Dir      Apt
           135        RUMBLE                 RD
 City MACON                   ST GA   Zip 31211        Phone 678 524 06

 Mailing Address   Del
 Address Line 1                         Line 2
 Street  Number  Dir          Name           Type    City Dir      Apt
                       SAME
 City                         ST      Zip
                                          Previous Addresses in last 2 years
  Message 1884      2133                                                 01
 1884 STREET NAME NOT FOUND IN ZIP CODE AREA
               15-lett                                 21-narr  23-alau  24-del
```

DONE:

- Press ENTER to commit to database

```
CHANGE                      SESSION SUMMARY - DONE                  DONE
  Month 10 06                                                          01



   AU ID   Prog  Med COA    Elig   - Status -   - Benefit --   Outstanding
                            Req    Code Cfirm    Amt   Cfirm  Verifications
 XXXXX0214 MA      Q01       N      P



 Message 0428
 0428 PRESS ENTER TO COMMIT
                                      16-prwp  20-edd  21-narr
```

APP1:

- No data to enter
- Press PF13 to return to AMEN

```
UPDATE                  PROCESS APPL MONTHS - APP1                  APP1
                                                                      01

 AU ID XXXXX0214   Prog MA
 HOH Name TRACEY         SMITH                    Client ID 180000332


           Sel  Bnft   Status   Med COA       Disposition Status
                Month
                10 06    P        Q01      WAITING FINALIZATION
                11 06    P        Q01      WAITING FINALIZATION









 Message
 0543 THIS DATA WILL BE WRITTEN TO THE DATABASE
 13-amen
```

FINALIZE THE CASE – Q

AMEN:

- Select Q
- Press ENTER

```
                  ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                AMEN

                                Selection Q
                 AU ID XXXXXXXXX            Client ID
              Screen ID                     As Of Date
   Benefit Month (MM YY)                   Notice Type



   A. Name/Part Inquiry      J. Registration          R. Interim/Hist Change
   B. AU/Client Inquiry      K. Add A Person          S. QRF Change
   D. Address Inquiry        L. Add A Program         Y. Spndwn Med Expnse Update
   E. Trial Budget           M. Reinstatement         Z. Spndwn Med Expnse Inquiry
   F. Trial Eligibility      N. Initiate Review       1. Spndwn Authorization
   G. Batch Print Request    O. Interview             5. Prior Medicaid Copy
   H. Notice History         P. Process Appl Months   6. Finalize Prior Medicaid
   I. SPA Inquiry            Q. Finalize Application
```

APP2:

- No data to enter
- Press ENTER

```
UPDATE                    FINALIZE APPLICATION - APP2                APP2
                                                                       01

 AU ID XXXXX0214   New MA ID
 HOH Name TRACEY         SMITH                    Client ID 180000332

 Finalize
       Sel  Bnft   Status   Prog   Med COA        Disposition Status
            Month
        Y   10 06    P       MA      Q01       WAITING FINALIZATION
            11 06    P       MA      Q01       WAITING FINALIZATION









 Message
```

ELIG 10-06

- Ensure that Ms. Smith's case is denied for the application month
- Enter Y in the Confirm field

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 10 06                                                           01

 AU ID XXXXX0214    Prog MA    Prog Type A    Med COA Q03
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  D    347           100506   100206
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 TRACEY SMI   SE OT        RE   D 100506 347  100206



 Message
```

MAFI 10-06

- Ensure that Ms. Smith's budget is correct
- Enter Y in the Confirm field

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI              MAFI    A
  Month 10 06                    8991   10 05 06
 AU ID XXXXX0214   Prog MA   Prog Type A        Med COA Q03

 Resources                         Income Test Continued
   Resource Limit          4000.00   Allocated Income           .00
   Total Resources          126.00   Gross Unearned Income   800.00
 Patient Liability/Cost Share        General Inc Deduction    20.00
   Pat Liability Income        .00   Net Unearned Income     780.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income              780.00
   IME Amount                  .00   Income Limit            817.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons 347             Recon Ind
 Notice Type 0005           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 06        Strat
 Message

  13-note
```

ELIG 11-06

- Ensure Ms. Smith's case is active ongoing
- Enter Y in the Confirm field

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
  Month 11 06                                                          01

 AU ID XXXXX0214    Prog MA    Prog Type A    Med COA Q01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   100206   110106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 TRACEY SMI   SE OT        RE   A 100506      100206  110106



 Message
```

MAFI 11-06

- Ensure Ms. Smith's budget is correct ongoing
- Enter Y in the Confirm field
- Press PF13 to access the NOTE screen

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 11 06                    8991   10 05 06
 AU ID XXXXX0214   Prog MA   Prog Type A        Med COA Q01

 Resources                          Income Test Continued
   Resource Limit          4000.00   Allocated Income           .00
   Total Resources          126.00   Gross Unearned Income   800.00
 Patient Liability/Cost Share        General Inc Deduction    20.00
   Pat Liability Income        .00   Net Unearned Income     780.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income              780.00
   IME Amount                  .00   Income Limit            817.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm Y   Reasons                 Recon Ind
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat
 Message

  13-note
```

NOTE:

- Enter the text shown
- Press ENTER

```
UPDATE                        NOTICE TEXT - NOTE                     NOTE


 HOH Name TRACEY       SMITH                    Client ID 18000332
 AU ID XXXXX0214   Prog MA


       BY POLICY YOU ARE NOT ELIGIBLE FOR QMB BENEFITS UNTIL NOVEMBER 2006.
       OCTOBER QMB benefits are denied.  Policy Manual, page 2143-4.




       Message
```

APP2:

- Enter Y in the Finalize field
- Press ENTER

```
UPDATE                    FINALIZE APPLICATION - APP2                APP2
                                                                       01

 AU ID XXXXX0214   New MA ID
 HOH Name TRACEY         SMITH                    Client ID 180000332

 Finalize Y
       Sel  Bnft   Status   Prog   Med COA        Disposition Status
            Month
            10 06    D       MA      Q03       FINALIZED BY WORKER
            11 06    A       MA      Q01       FINALIZED BY WORKER









 Message 0690
 0690 IF APPLICATION FINAL IS COMPLETE, PLEASE FINALIZE
```

The O, P, and Qs of SUCCESS

"O"	ALL _____	ALL _____
"P"	_____ Programs	Each _____ Separately
"Q"	Each _____ Separately	Each Month _____

How many RACF IDs are needed to finalize the case?

_____

Disposition Status APP 1

Final Edits Needed

"O" _____ "P" _____

"Q" _____

Waiting Finalization

"O" _____ "P" _____

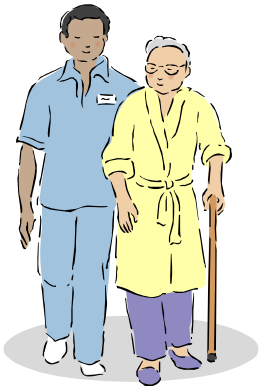
"Q" _____

Finalized by Worker

"O" _____ "P" _____

"Q" _____

Summary Notice History: John Dunne



AMEN:

- Select H
- Enter AU ID 000000019

NHIS:

- Enter Y in the Select field next to the notice type
- Press ENTER

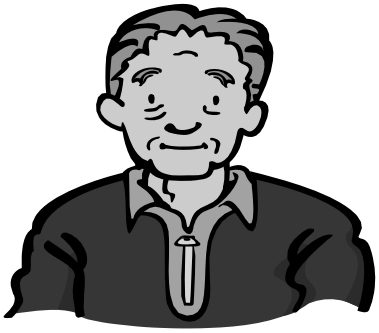
NCON:

- Read the entire notice
- Press ENTER to scroll forward

NHIS:

- PF3 to return to AMEN

Jonathan Daniels



Background: Jonathan Daniels is a 67-year-old widower; he resides in his own home.

Your Assignment:

- Review Mr. Daniel's application.
- Answer the policy questions relating to Mr. Daniels.
- Review the verification that is available to you.
- Complete the attached Verification Checklist.
- Complete the attached Burial Exclusion Form
- Complete the attached manual budget, Form 172.
- Then complete the initial application process to determine if Mr. Daniel's is eligible for Q-Track benefits.

Compare your MAFI screens to the ones in your Participant Guide.

Mr. Daniels is an "independent study" case. The trainer will not go through the screens with you, but will be available to answer questions. Please work independently on this case.

Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)
   _____
   _____
   _____
   ATTN: _____

APPLICATION RECEIVED 10/02/06
REGISTERED AU ID XXXX00211

3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial) Daniels, Jonathan Mailing Address	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial)
Street Address 522 Lakeside Dr	Mailing Address
City Atlanta State GA Zip 30303 Do you own/are you purchasing home? ☑ Y ☐ N	City State Zip
Phone 404-989-2323 County Fulton E-Mail Address	Phone E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): Jonathan Maiden/other name(s):	Birthdate 9/3/38	Sex M	Race W	U.S. Citizen (Yes or No) Yes	Social Security Number 521601 XXXX	Marital Status W
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? ☐ **Yes** ☐ **No**

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

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

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

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HEALTH INSURANCE:

Do you have Medicare?	Type of Coverage	Effective Date:	Have you ever received SSI?
☑ **Yes** ☐ **No** Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ **Yes** ☑ **No**	☑ **Part A** (hospital) ☑ **Part B** (doctor) **Part D** (RX)	9/2003 Medicare Number: 526 01 XXXA	☐ **Yes** ☑ **No** If so, when did it end?
Does your spouse have Medicare? ☐ **Yes** ☐ **No**	Type of Coverage ☐ **Part A** ☐ **Part B** **Part D**	Effective Date: Medicare Number:	Has your spouse ever received SSI? ☐ **Yes** ☐ **No** If so, when did it end?

Do you have other health insurance? ☐ **Yes** ☑ **No**

Does your spouse have other health insurance? ☐ **Yes** ☐ **No**

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live? ☐ **Yes** ☑ **No**

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☑ **Yes** ☐ **No** If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed
Car	02	Toyota	Corolla	$4000	Ø

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RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	☑ Yes	☐ No	Funeral plans/ prepaid burial item	☐ Yes	☑ No
Savings account	☐ Yes	☑ No	Burial plots or contracts	☐ Yes	☑ No
Government bonds	☐ Yes	☑ No	Stocks and bonds	☐ Yes	☑ No
Trust funds	☐ Yes	☑ No	Other (IRA, CD, promissory note, etc.)	☐ Yes	☑ No

Have you or your spouse given away any assets for less than its value? ☐ Yes ☑ No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
Checking	1254879 62-569	$351	First Union

Do you or your spouse have a life insurance policy? ☑ Yes ☐ No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
Jonathan	Primerica	45789623-AS	$15,000	Ø

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security — SSI — Wages/ Self-Employment
Railroad Retirement Benefits — Veterans' Benefits — Trust or Annuity Payments
Pensions/ Retirement Benefits — Rental Income Paid to You — Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
Jonathan	RSDI	Social Security	$811	monthly	526001 XXXXA

Are you a veteran? ☐ Yes ☑ No Is your spouse a veteran? Yes No

Where did you and spouse work in the past? _____

Do you or your spouse have any unpaid medical bills ? ☐ Yes ☑ No

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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 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: Jonathan Daniels	**Date:** 10/2/09
Signature of Applicant's Spouse or Representative:	**Date:**

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DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the Unit States Department of Homeland Security (DHS) of my/my children's citizenship or alien 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	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)

(check whichever applies)

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

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth(city,state,country)	U.S. Citizen	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)
Jonathan Daniels	Atlanta, GA, US	✓		

(check whichever applies)

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

Jonathan Daniels
SIGNATURE (PARENT/GUARDIAN)

10/2/06
(DATE)

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

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MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JONATHAN DANIELS

MEDICARE CLAIM NUMBER
526-01-XXXXA

SEX
MALE

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) 09-2003
MEDICAL INSURANCE (PART B) 09-2003

SIGN HERE Jonathan Daniels

POLICY QUESTIONS

- **For what type of Medicaid is the AR applying (remember the CMD order of eligibility)?**

- **What is the SOP for this application?**

- **What type of interview is required?**

- **What mandatory forms must be completed?**

- **How will categorical relationship be verified for this AR?**

- **How will enumeration be verified?**

- **Does the AR need to apply for any other benefits?**

- **What are the AR's countable resources?**

- **How will each resource be verified?**

- **What is the AR's countable income?**

- **How will each type of income be verified?**

COMPLETE THE VERIFICATION CHECKLIST FOR THIS AR.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between _____AM and _____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

BURIAL EXCLUSION
☐FBR or☐ NON-FBR
(Check Which)

Complete form for each A/R & spouse, as needed. Application/Review date: _____

BURIAL CONTRACT:

a. Name of Funeral Home: _____ Phone #: _____

b. Contract owned by A/R or Spouse? ☐ Yes ☐ No If no, who owns: _____

c. Is contract itemized? ☐ Yes ☐ No

d. Is contract designated for A/R or spouse? ☐ Yes ☐ No

e. Is contract paid in full? ☐Yes ☐ No If yes, list purchase price $_____ Date: _____

f. Determine the value of the paid in full burial space items. List below:

Burial Space Item	$ Value
Total	

g. Subtract $ amount in F from $ amount in E.

As of: E - F = Countable non-burial space amt.

Date _____ $ _____ - _____ = $ _____

IF	THEN
Contract owned by other than A/R or Deemor,	Do not count as a resource. Investigate for possible transfer of assets. Section 2342.
Contract owned by A/R/Deemor & is irrevocable,	Treat same as revocable contract.
Contract owned by A/R/Deemor, is Non-itemized, revocable & for family member,	Count as a resource the full "Current Refund Value" of the contract. See above.
Contract owned by A/R/Deemor, is itemized, revocable & paid in full,	Count the "Countable non-burial space amt." shown above.
Contract owned by A/R/Deemor, is itemized, revocable & **NOT** paid in full & is not designated or for non-family member,	Count the refund value of burial space items for those non family members.
Contract Not paid in full,	The burial space items that are **PAID** for may be designated for burial. Any PAID for NON burial space items are a countable resource.

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BURIAL EXCLUSION DOCUMENTATION

BURIAL FUNDS: Attach copy of Form 985. If totally excluded, do not count interest accrued.

LIFE INSURANCE POLICIES: Attach copy of "Record of Life Insurance Policies".

h. From Form 985, enter value of any **Burial Fund(s)**:

Designated Value:	Value + accrued interest (Use only if unable to use for Burial Exclusion allowance.)
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____ Total	$ _____ Total

NOTE: If part of a burial fund is not to be excluded, compute the percentage of the countable portion to use in subsequent reviews. Use the same procedure as in e, f & g of Burial Contracts.

i. From **"Record of Insurance Policies"**, enter Face Value (FV) and Cash Surrender Value (CSV) of each policy. Use CSV only if unable to use for Burial Exclusion allowance.

Documentation:

FV	CSV
$	$
$	$
$	$
$	$
$	$
$	$
Totals:	

j. **Burial Assets**

Total of Burial Contracts: (g.) $ _____
Total of Burial Funds: $ _____
Total of FV of Life Insurance: $ _____
Total Burial Assets: $ _____

k. **Burial Exclusion Allowance:** _____

Contracts used for Burial Exc. $ _____
Burial Funds used for Burial Exc.$ _____
FV of Life Ins. used for Bur. Exc. $ _____
Actual amt. designated for Burial $ _____
(Total should be = or < than $1500/$10,000)

l. **Total to count toward resource** limit **of A/R:** (Use **only** if **all** burial assets are not exempt.)

Burial Contract (g): _____
Burial Funds (2nd column h. above) _____
CSV of Life Insurance (i. above): _____
Total countable burial assets: _____

Does this amount combined with other assets exceed the resource limit?
Yes ☐ No ☐

m. Enter the total amount in k. in SUCCESS, RES1, as a "burial contract" (BC) to be excluded. Count those not excluded for burial as a countable resource (l. above). Enter total in l. above in SUCCESS, RES3, as other countable resource (OC), and document case on REMA.
Add text to the notice if A/R's AU is closed/denied due to excess burial assets: "Due to burial policy changes, your resources exceed the allowable limit. Manual reference Sections 2311, 2312, 2323."

DHR 05/09

Georgia Department of Human Resources

ABD Medicaid Individual/Couple/Spouse to Spouse Deeming Budget Sheet

AU Name:_____ AU # _____
Class of Assistance:_____ Living Arrangement: _____ Date:_____

Section A- Individual Calculation: Use to budget a Medicaid Individual OR a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) in LA-A or LA-B. Not for use on Medicaid Cap budgeting.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	
UNEARNED INCOME				
1. Enter A/R's Total GROSS Unearned Income				
2. Subtract $20 General Deduction. (Subtract $0 from IBON)				
3. Net Unearned Income (Line 1 minus Line 2)				
Earned Income (Go to Line 11 if no earned income)				
4. Enter A/R's Total GROSS Earned Income.				
5. Subtract remainder of $20 General Deduction.				
6. Subtotal (Line 4 minus Line 5)				
7. Subtract $65 Earned Income Deduction.				
8. Subtotal (Line 6 minus Line 7)				
9. Subtract ½ of Line 8.				
10. Subtotal (Line 8 minus Line 9)				AMN 3
TOTAL INCOME				Mo BP
11. Total Net Income (Line 3 plus Line 10)				
12. INDIVIDUAL Income Limit (FBR, Q-track, MNIL)				
13. Surplus/Deficit OR 1st Potential AMN Spenddown (Line 11 minus Line 12)				

NOTE: If a surplus exists on Line A.13, **STOP** (the A/R is ineligible) unless AMN. If a deficit exists or the COA is AMN continue.
NOTE: For Q Track eligibility, A/R must be eligible for the COA as an individual (Section A), in order to meet eligibility for the same COA as an individual with an ineligible spouse (Section C(. Example: A/R is SLMB eligible as an individual (Section A) but appears to be QMB eligible under Spouse to Spouse Deeming budget (Section C). A/R will only be eligible for SLMB, since s/he is ineligible for QMB as an individual.

Section B- Deeming From Ineligible Spouse: Use to budget a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) in LA-A or LA-B.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____
UNEARNED INCOME			
1. Enter Ineligible Spouse's GROSS UNEARNED Income (Exclude IBON)			
2. Subtract Living Allowance for Ineligible Child(ren) minus the Child(ren)'s Income			
3. Ineligible Spouse(s)' UNEARNED Income to include in Section C (Line 1 minus Line 2)			
Earned Income			
4. Enter Ineligible Spouse(s)' GROSS EARNED Income.			
5. Subtract any portion of Living Allowance not subtracted from Unearned Income.			
6. Ineligible Spouse(s)' EARNED Income to include in Section C (Line 4 minus Line 5)			

Form 172 (R. 01/06)

Georgia Department of Human Resources

See REVERSE SIDE for Continuation of Budgeting

AMN Only: If the combined total of Lines B.3 and B.6 does NOT exceed ½ the Individual MNIL, STOP and use the 1st Potential Spenddown from Line A.13 as the AMN Spenddown.

Section C- Spouse-to-Spouse Deeming or Couple Calculation: Use to budget a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) OR a Medicaid Couple in LA-A or LA-B.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	
UNEARNED INCOME				
1. Enter Total GROSS Unearned Income of A/R and Unearned Income deemed from Ineligible Spouse (Line A.1 plus UNEARNED Income from Line B.3) OR Total GROSS Unearned Income of Medicaid Couple.				
2. Subtract $20 General Deduction. (Subtract $0 from IBON)				
3. Net Unearned Income (Line 1 minus Line 2)				
Earned Income (Go to Line 11 if no earned income)				
4. Enter Total GROSS Earned Income of A/R and Earned Income deemed from Ineligible Spouse (Line A.4 plus EARNED Income from Line B.6) OR Total GROSS Earned Income of Medicaid Couple				
5. Subtract remainder of $20 General Deduction.				
6. Subtotal (Line 4 minus Line 5)				
7. Subtract $65 Earned Income Deduction.				
8. Subtotal (Line 6 minus Line 7)				
9. Subtract ½ of Line 8.				
10. Subtotal (Line 8 minus Line 9)				AMN 3
TOTAL INCOME				Mo BP
11. Total Net Income (Line 3 plus Line 10)				
12. COUPLE Income Limit (FBR, Q-track, MNIL)				
13. Surplus/Deficit OR 2nd Potential AMN Spenddown (Line 11 minus Line 12)				

AMN Only: Use the 1st Potential Spenddown (Line A.13) or 2nd Potential Spenddown (Line C.13), whichever is greater.

NOTE: For Q Track eligibility, A/R must be eligible for the COA as an individual (Section A), in order to meet eligibility for the same COA as an individual with an ineligible spouse (Section C). Example: A/R is SLMB eligible as an individual (Section A) but appears to be QMB eligible under Spouse to Spouse Deeming budget (Section C). A/R will only eligible for SLMB, since s/he is ineligible for QMB as an individual.

Documentation/Computation Space:

Form 172 (R. 01/06)

MAFI 10-06

```
FINALIZE                MA FINANCIAL ELIGIBILITY - MAFI              MAFI
Month 10 06                    8991   10 05 06
AU ID 870310219   Prog MA   Prog Type A        Med COA Q03

Resources                          Income Test Continued
   Resource Limit          4000.00   Allocated Income           .00
   Total Resources          351.00   Gross Unearned Income   900.00
Patient Liability/Cost Share        General Inc Deduction    20.00
   Pat Liability Income        .00   Net Unearned Income     880.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income              880.00
   IME Amount                  .00   Income Limit            980.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

Bnft Eff Date 100506 Bnft Confirm   Y   Reasons                 Recon Ind
Notice Type                Waive Timely Ntc  Period     Notice Override
Review Begin Date 09 06    Review End Date 10 06        Strat
Message

  13-note                    17-mo< 18-mo>
```

MAFI 11-06

```
FINALIZE                MA FINANCIAL ELIGIBILITY - MAFI              MAFI
Month 11 06                    8991   10 05 06
AU ID 870310219   Prog MA   Prog Type A        Med COA Q03

Resources                          Income Test Continued
   Resource Limit          4000.00   Allocated Income           .00
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   Pat Liability Income        .00   Net Unearned Income     880.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income              880.00
   IME Amount                  .00   Income Limit            980.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

Bnft Eff Date 100506 Bnft Confirm   Y    Reasons                 Recon Ind
Notice Type                Waive Timely Ntc  Period     Notice Override
Review Begin Date 09 06    Review End Date 10 07        Strat
Message

  13-note                    17-mo< 18-mo>
```

THOMAS HONG
Nursing Home Initial Application, with community spouse

Recall that Mr. Hong was registered during the Screening and Registration module. Refer to his application in the case record.

Your Assignment:

- Complete the policy questions related to this case.
- Assume that you interviewed Ms. Hong about her husband's situation.
- Review the verification that is available to you.
- Prepare a verification checklist to send to Ms. Hong.
- Complete the Medicaid Cap budget and the Patient Liability budget.
- Complete the Interview (O) process:
    - You will complete most of the screens independently. Remember to use the Documentation Standards.
    - Remember to enter Mr. Hong's previous residential address on PREV.
    - The coding of the STAT and DEM1 will be a little different from the Q track cases we have been working on, so stop at STAT. The trainers will instruct the participants on the completion of the STAT and DEM1 screens.
    - Nursing Home cases also have a conditional screen called "INST" to capture the information about the nursing home and patient liability. Stop when you see the INST screen and wait for the trainers to walk through this screen with you.

- Review the verification received and complete the Burial Exclusion Form.
- Complete the Transfer of Assets Form, indicating what assets Mr. Hong will need to transfer.
- Complete the "P" process
- Trainers will assist you with the "Q" process.

Compare your MAFI screens to the ones in your Participant Guide.

Mr. Hong will need the prior month of September since he entered the nursing home on 9/30. The trainers will walk you through the process of approving prior months.

POLICY QUESTIONS

- **For what type of Medicaid is the AR applying (remember the CMD order of eligibility)?**
- **What is the SOP for this application?**
- **What type of interview is required?**
- **What mandatory forms must be completed?**
- **How will categorical relationship be verified for this AR?**
- **How will enumeration be verified?**
- **Does the AR need to apply for any other benefits?**
- **What are the AR's countable resources?**
- **How will each resource be verified?**
- **What is the AR's countable income?**
- **How will each type of income be verified?**

COMPLETE THE VERIFICATION CHECKLIST FOR THIS AR.

- **What information will be verified directly from the source (ie property search)?**

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between _____AM and _____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

BURIAL EXCLUSION
☐FBR or☐ NON-FBR
(Check Which)

Complete form for each A/R & spouse, as needed. Application/Review date: _____

BURIAL CONTRACT:

a. Name of Funeral Home: _____ Phone #: _____

b. Contract owned by A/R or Spouse? ☐ Yes ☐ No If no, who owns: _____

c. Is contract itemized? ☐ Yes ☐ No

d. Is contract designated for A/R or spouse? ☐ Yes ☐ No

e. Is contract paid in full? ☐Yes ☐ No If yes, list purchase price $_____ Date: _____

f. Determine the value of the paid in full burial space items. List below:

Burial Space Item	$ Value
Total	

g. Subtract $ amount in F from $ amount in E.

As of: E - F = Countable non-burial space amt.

Date _____ $ _____ - _____ = $ _____

IF	THEN
Contract owned by other than A/R or Deemor,	Do not count as a resource. Investigate for possible transfer of assets. Section 2342.
Contract owned by A/R/Deemor & is irrevocable,	Treat same as revocable contract.
Contract owned by A/R/Deemor, is Non-itemized, revocable & for family member,	Count as a resource the full "Current Refund Value" of the contract. See above.
Contract owned by A/R/Deemor, is itemized, revocable & paid in full,	Count the "Countable non-burial space amt." shown above.
Contract owned by A/R/Deemor, is itemized, revocable & **NOT** paid in full & is not designated or for non-family member,	Count the refund value of burial space items for those non family members.
Contract Not paid in full,	The burial space items that are **PAID** for may be designated for burial. Any PAID for NON burial space items are a countable resource.

DHR 05/09

BURIAL EXCLUSION DOCUMENTATION

BURIAL FUNDS: Attach copy of Form 985. If totally excluded, do not count interest accrued.

LIFE INSURANCE POLICIES: Attach copy of "Record of Life Insurance Policies".

h. From Form 985, enter value of any **Burial Fund(s)**:

Designated Value:	Value + accrued interest (Use only if unable to use for Burial Exclusion allowance.)
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____ Total	$ _____ Total

NOTE: If part of a burial fund is not to be excluded, compute the percentage of the countable portion to use in subsequent reviews. Use the same procedure as in e, f & g of Burial Contracts.

i. From **"Record of Insurance Policies"**, enter Face Value (FV) and Cash Surrender Value (CSV) of each policy. Use CSV only if unable to use for Burial Exclusion allowance.

Documentation:

FV	CSV
$	$
$	$
$	$
$	$
$	$
$	$

Totals:

j. **Burial Assets**

Total of Burial Contracts: (g.) $ _____
Total of Burial Funds: $ _____
Total of FV of Life Insurance: $ _____
Total Burial Assets: $ _____

k. **Burial Exclusion Allowance:** _____

Contracts used for Burial Exc. $ _____
Burial Funds used for Burial Exc.$ _____
FV of Life Ins. used for Bur. Exc. $ _____
Actual amt. designated for Burial $ _____
(Total should be = or < than $1500/$10,000)

l. **Total to count toward resource** limit **of A/R:** (Use **only** if **all** burial assets are not exempt.)

Burial Contract (g): _____
Burial Funds (2nd column h. above) _____
CSV of Life Insurance (i. above): _____
Total countable burial assets: _____

Does this amount combined with other assets exceed the resource limit?
Yes ☐ No ☐

m. Enter the total amount in k. in SUCCESS, RES1, as a "burial contract" (BC) to be excluded. Count those not excluded for burial as a countable resource (l. above). Enter total in l. above in SUCCESS, RES3, as other countable resource (OC), and document case on REMA.
Add text to the notice if A/R's AU is closed/denied due to excess burial assets: "Due to burial policy changes, your resources exceed the allowable limit. Manual reference Sections 2311, 2312, 2323."

DHR 05/09

_____ County
Department of Family and Children Services

NOTIFICATION REQUIREMENT: TRANSFER OF ASSETS TO SPOUSE
(Spousal Impoverishment)

_____

_____ _____
Date

_____

_____

_____

_____ _____
Recipient Name Medicaid Number

_____
Name of Spouse

The above named individual has been determined eligible for Medicaid Benefits. As part of the eligibility determination process, the individual has agreed to transfer ownership of his/her resources to his/her spouse. In order for the individual to remain eligible for Medicaid, the resources named below must be transferred to the spouse no later than _____(the annual review date). Your Medicaid Eligibility Specialist must be given verification of the transfer no later than the annual review date. If the resources are not transferred by _____(the annual review date), the individual will become ineligible for Medicaid effective _____(month).

Below is a list of the resources which must be transferred, and their values:

RESOURCE	VALUE

I agree that the assets listed above are to be transferred to my spouse. **YES** **NO** (circle one)
I **DO** **DO NOT** (circle one) want to make my income available to my spouse.
I want to give: ☐ the maximum amount possible or ☐ $_____ per month to my spouse.

The above action will be effective _____. _____
Applicant's/Authorized Representative's Signature

_____ _____
Signature of Medicaid Eligibility Specialist Telephone Number

REQUEST FOR FAIR HEARING

Client Name: _____ AU # _____

Today's Date:	Telephone Number where you can be reached:	
Use this space to tell us why you want a fair hearing:		

Check One:

☐ I do not want to continue receiving the benefits I now receive while waiting for the hearing decision.

☐ I want to continue receiving the benefits I now receive while waiting for the decision. I understand that I will be required to repay the Department of Human Resources any overpayment in benefits to which I was not entitled as determined by the hearing official.

If you want a fair hearing, fill out this form, cut it off at the dotted line, and mail or bring it to your Division of Family and Children Services.

RIGHT TO A COUNTY CONFERENCE

If you are not satisfied with this decision, you have the right to a conference with your county department if you so request. During the conference you may speak for yourself, be represented by legal counsel, a friend, or other spokesperson. This conference is optional and will not affect your right to a fair hearing should you request one.

RIGHT TO A FAIR HEARING

You can have a fair hearing of your case if you don't agree with our decision. At the hearing you'll have a chance to explain why you disagree. You may request a fair hearing either orally or in writing by notifying the County Division of Family and Children Services.

You have 30 days from the date on this form to request a hearing. If you request a hearing orally, you have 15 days from the date of your oral request to submit your request in writing.

A representative of the Department of Human Resources would hold the hearing in your county. An attorney or other representative of your choice may represent you at the hearing. Any member of our staff will furnish you any necessary forms and help you file your appeal. Free legal services may be available to you in your community. If you are interested in legal services, contact your worker who will provide the number for free legal services.

If you want to request a hearing or ask any questions about how a fair hearing works, please call your county Division of Family and Children Services at their phone number listed on the form or complete the attached Request for Fair Hearing and return it to your County Department.

If you want a fair hearing, fill out this form, cut it off at the dotted line, and mail or bring it to your Division of Family and Children Services.

MEDICAID CAP MAO BUDGET SHEET

☐ INITIAL DETERMINATION ☐ REDETERMINATION ☐ SPECIAL REVIEW DATE _____

NAME OF APPLICANT(S) OR RECIPIENT(S)	CASE NUMBER(S)
1.	
2.	

A. UNEARNED INCOME (U.I.)	A/R in MTF	SPOUSE in MTF	B. EARNED INCOME (E.I.)	A/R in MTF	SPOUSE in MTF
1.			1.		
2.			2.		
3.			3.		
4.			4. Gross Earned Income		
5. Subtotal					

c. ELIGIBILITY DETERMINATION	INDIVIDUAL IN MTF		INDIVIDUAL IN MTF	
1. Gross Medicaid CAP				
2. Subtract Adjusted Gross U.I. (A 5)				
3. Subtotal				
4. Subtract Gross E.I. (B 4)				
5. SURPLUS/DEFICIT				

ADDITIONAL INFORMATION / COMPUTATION SPACE

Georgia Department of Human Resources
Patient Liability Budget Sheet

AU Name: _____ AU Number: _____ Date: _____

Section A – Diversion of Income to Dependents	Month _____	Month _____	Month _____
1. Enter Diversion Standard (FBR, SON, CSMNS, DFMNS).			
2. Subtract Spouse/Dependent's ADJUSTED GROSS Income, including ISM, after allowing Mandatory Deductions.			
3. TOTAL DIVERTED INCOME (Line 1 minus Line 2)			
Section B – Incurred Medical Expenses (IMEs)			
1. Enter Insurance Premium			
2. Enter Other IMEs			
3. Enter Other IMEs			
4. TOTAL IMEs (Total of Lines 1 through 3)			
Section C – Patient Liability Budget			
1. Enter recipient's SSI Income (month of admission only)			
2. Enter recipient's ADJUSTED GROSS Unearned and Earned Income after allowing mandatory deductions.			
3. Subtotal (Line 1 plus Line 2)			
4. Subtract Medicare Premium if applicable (through month after month of Medicaid approval)			
5. Subtotal (Line 3 minus Line 4)			
6. Subtract Protected income (All, ½, 0). (Admission/Discharge Date _____).			
7. Subtotal (Line 5 minus Line 6)			
8. Subtract Personal Needs Allowance.			
9. Subtotal (Line 7 minus Line 8)			
10. Subtract Diverted Income (From Line A.3)			
11. Subtotal (Line 9 minus Line 10)			
12. Subtract IMEs (from Line B.4 or Averaged IMEs)			
13. Patient Liability (Line 13 minus Line 14)			

Form 968 (R. 09/04)

ADDR

- Enter a Y for previous addresses in the last 2 years

PREV

- Enter Mr. Hong's Residential address prior to his admittance to the Nursing Home
- He has lived at this address from October 1945 to September 2006
- He owns the property

```
INTERVIEW             PREVIOUS HOUSEHOLD ADDRESSES - PREV            PREV 01
  Month 11 06                                                          01

 HOH Name THOMAS         HONG                     Client ID

 Del
 Address Line 1                          Line 2
 Street  Number   Dir          Name           Type   City Dir    Apt
           785                  HARRIS         ST     SW
 City RICHLAND                 ST GA   Zip 30265
 From (MM YYYY) 10 1945  To (MM YYYY) 09 2006   Owned by Household Member Y

 Del
 Address Line 1                          Line 2
 Street  Number   Dir          Name           Type   City Dir    Apt

 City                          ST      Zip
 From (MM YYYY)          To (MM YYYY)           Owned by Household Member


                                                                More Addresses
  Message
```

STAT

- When the A/R has a community spouse, the spouse's relationship code is "OR"
- The spouse's financial responsibility code is "NA"
- It is imperative that these codes be correct so the system can correctly count the resources and divert income to the spouse

```
INTERVIEW                  ASSISTANCE STATUS - STAT                  STAT    A
  Month 11 06                     0097   10 05 06                      01

 AU ID 106514343  Prog MA  Prog Type A  Prev ABD Type     Med COA L01   Claim N
    CO 049    LO 049    Load ID 1065    Conversion Date

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty----  Appeal
 Stat    Reasons      Date     Date     Date     Date    Type  End Date    Ind
  P                  100306   100306
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T   Date
 THOMAS HON   SE OT        PN   P 100306       100306
 POLLY  HON   OR OT        NA   P 100306       100306



  Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                              20-rmen       22-alau(arch)      23-alau(curr)
```

DEM1

```
INTERVIEW                 CLIENT DEMOGRAPHIC 1 - DEM1                DEM1 01
  Month 11 06                     0097   10  05  06

 Client Name THOMAS HONG                          Suf       Client ID 106594364

 Alt   SSA/SSN   SSN Appl      SSN1     V   More        DOB      V Sex Race Eth
 Name  Appl For    Date                     SSNs    (MM DD YYYY)
                          200 01 XXXX  CA           07 10 1933  OT  M   W   Y


 GA   Marital   Living   RSM  Min Par  Boarder   Amt Paid -- Family Planning --
 Res  Status    Arrngmt Ad/Ch   /LA    Num Meals for Meals  Referral     Date
  Y     A         NH


  Concurr   SSI   Depriv  V  Prenatal Care   ---------- Pregnant ---------  FTC
 Out of St  Recip            Ind  Good Cse   Term/Due  Term/Due  V  Num V  Code
 CA  FS MA                                    Code      Date        Exp
 N   N  N    N


 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"

               15-lett                       16-crs            23-alau
```

INST (SEE DMA-59)

```
INTERVIEW                        INSTITUTION - INST                      INST 01
 Month 11 06                     A137   10 05 06                        01

 Fllhqw#Qaph#WKRPDV#########KRQJ##########Fllhqw#LG#439843:6;###################


 D Inst   Prov    Admission Discharge   NH     LOC  V  Payment   -- Payment --
   Type    ID       Date      Date    Perdiem  Auth    Auth Date Term DT   Rsn
    NH  000624951A  093006               ?      S  OT   093006   020220     L

 Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
 Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V
                                                           A      88.50   BE

   Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
 Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met            Ind
                                                   Y     NH   401.9   N
#########################################################Pruh#Lqvwlwuwlrqv######
#Phvvajh#######################################################################
##########480lhww#490pphq#################################################570ghl#
```

```
-------------------------------#LQVWLWXWLRQ#-------------------------------##
#4323625339#36=38#SP#LPD#ZRUNHU/#;:8k/#438/#DQ\/#7:;089:07686######
#UHDVRQ#IRU#SURWHFWLRQ=PU1#KRQJ#HQWHUHG#QK#GLUHFWO\#IURP#KLV#KRPH#RQ#<263239#VR#
SURWHFWLQJ#DOO#RI#LQFRPH#IRU#VHSWHPEHU####
#W\SH#RI#LPH=#bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb#############################
#OLPLWHG#VWD\#H[WHQVLRQ0#QHZ#GPD9#UHFHLYHG=bbbbbbbbbbbbbbb~GDWH¢1#############
#QHZ#OHYHO#RI#FDUHB##\2Q#+Q,##################################################
#JDS#LQ#SD\PHQW#\2Q#+Q,1##LI#\HV/#H[SODLQ=#bbbbbbbbbbbbbbbbbbbbbbbbbbbbbb#####
#=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb#####
GPD08<#uvhg#wr#yhuli|#Ohyhl#ri#Fauh1#
```

Process/Finalize Application Months

ELIG A 10-06

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 10 06                                                           01

 AU ID 106514343    Prog MA    Prog Type D   Med COA L01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   100306   100106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 THOMAS HON   SE OT        RE   A 100506      100306  100106
 THOMAS HON   OR OT        NA   A 100506      100306  100106





 Message
```

MAFI 10-06

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 10 06                    0601   10 05 06
 AU ID 106514343   Prog MA   Prog Type D        Med COA L01

 Resources                          Income Test Continued
   Resource Limit        101540.00   Allocated Income           .00
   Total Resources         5250.00   Gross Unearned Income  1700.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income    1700.00   Net Unearned Income    1700.00
   Medicare Premium          88.50   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance    50.00   Net Earned Income          .00
   Diversion Amount        1088.50   Net Income             1700.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt   473.00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

Process/Finalize Application Months

ELIG A 11- 06

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 11 06                                                           01

 AU ID 106514343    Prog MA    Prog Type D   Med COA L01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   100306   100106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 THOMAS HON   SE OT        RE   A 100506      100306  100106
 THOMAS HON   OR OT        NA   A 100506      100306  100106





 Message
```

MAFI 11- 06

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 11 06                    0601   10 05 06
 AU ID 106514343   Prog MA   Prog Type D        Med COA L01

 Resources                          Income Test Continued
   Resource Limit        101540.00   Allocated Income           .00
   Total Resources         5250.00   Gross Unearned Income  1700.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income    1700.00   Net Unearned Income    1700.00
   Medicare Premium          88.50   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance    50.00   Net Earned Income          .00
   Diversion Amount        1088.50   Net Income             1700.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt   473.00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

Prior Months Medicaid

Processing Prior Medicaid on SUCCESS

3 Steps from AMEN

Step 1 _____

Step 2 _____

Step 3 _____

Thomas Hong Prior Month Walk Through

- Review Thomas Hong's application for prior month(s) needed

AMEN

- Select "**5**" and enter Mr. Hong's AU ID number

```
                ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                AMEN

                              Selection 5
                AU ID 106514343            Client ID
            Screen ID                      As Of Date
Benefit Month (MM YY)                      Notice Type



A. Name/Part Inquiry      J. Registration          R. Interim/Hist Change
B. AU/Client Inquiry      K. Add A Person          S. QRF Change
D. Address Inquiry        L. Add A Program         Y. Spndwn Med Expnse Update
E. Trial Budget           M. Reinstatement         Z. Spndwn Med Expnse Inquiry
F. Trial Eligibility      N. Initiate Review       1. Spndwn Authorization
G. Batch Print Request    O. Interview             5. Prior Medicaid Copy
H. Notice History         P. Process Appl Months   6. Finalize Prior Medicaid
I. SPA Inquiry            Q. Finalize Application




Message 0019
0019 UPDATE COMPLETED SUCCESSFULLY
```

PMCO

- Select the prior month(s) needed. Enter "**Y**" beside each month requested.

```
UPDATE                   PRIOR MEDICAID COPY - PMCO                 PMCO
                                 5991   10 05 06

 HOH Name THOMAS        HONG                Client ID 106510738
                      AU ID 106514343   Appl Date 10 03 06


              Apply      Benefit       AU         Med
                          Month       Stat        COA

                          07 06
                          08 06
                y         09 06





Message 0963
 0963 PLEASE SELECT RETRO MONTH(S) FOR DATA COPY
```

Updating Prior Month Data for 09-06

AMEN

- Select "**R**"
- Enter **09 06** in the Benefit Month field and press ENTER

```
                ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                AMEN

                              Selection R
                AU ID 106514343              Client ID
             Screen ID                      As Of Date
Benefit Month (MM YY) 09 06                 Notice Type



A. Name/Part Inquiry      J. Registration          R. Interim/Hist Change
B. AU/Client Inquiry      K. Add A Person          S. QRF Change
D. Address Inquiry        L. Add A Program         Y. Spndwn Med Expnse Update
E. Trial Budget           M. Reinstatement         Z. Spndwn Med Expnse Inquiry
F. Trial Eligibility      N. Initiate Review       1. Spndwn Authorization
G. Batch Print Request    O. Interview             5. Prior Medicaid Copy
H. Notice History         P. Process Appl Months   6. Finalize Prior Medicaid
I. SPA Inquiry            Q. Finalize Application




Message 0019
0019 UPDATE COMPLETED SUCCESSFULLY
```

ADDR

The information entered into SUCCESS during the interview copies back to the prior months. The only screens we need to address are the ones that have different circumstances than what is currently in the data base.

- Fast path to **RES1** for Thomas Hong

RES1

- Update checking account balance for 09-06
- Fast path to DONE

DONE

- Press ENTER to commit to the data base.

Finalize Prior Months

AMEN

- Select "**6**" and the AU ID Number
- Delete **09 06** from the Benefit Month field
- Press ENTER

```
               ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                AMEN

                             Selection 6
                AU ID 106514343             Client ID
            Screen ID                       As Of Date
Benefit Month (MM YY)                       Notice Type



A. Name/Part Inquiry      J. Registration          R. Interim/Hist Change
B. AU/Client Inquiry      K. Add A Person          S. QRF Change
D. Address Inquiry        L. Add A Program         Y. Spndwn Med Expnse Update
E. Trial Budget           M. Reinstatement         Z. Spndwn Med Expnse Inquiry
F. Trial Eligibility      N. Initiate Review       1. Spndwn Authorization
G. Batch Print Request    O. Interview             5. Prior Medicaid Copy
H. Notice History         P. Process Appl Months   6. Finalize Prior Medicaid
I. SPA Inquiry            Q. Finalize Application




Message 0019
0019 UPDATE COMPLETED SUCCESSFULLY
```

FPME

- Do not enter “Y” to finalize
- Press ENTER to continue

```
UPDATE              FINALIZE PRIOR MEDICAID - FPME                 FPME


 HOH Name THOMAS     HONG                 Client ID 106510738
 AU ID  106514343

 Finalize

 Bnft     Status     Med     Spenddown     Disposition Status
 Month               COA      Amount

 07 06
 08 06
 09 06       P       LO1                   WAITING FINALIZATION









 Message
```

ELIG Prior Month 09-06

- Check the ELIG screen
- Enter “y” to confirm if correct

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 09 06                                                           01

 AU ID 106514343    Prog MA    Prog Type D   Med COA L01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   100306   090106    093006
 ---------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 THOMAS HON   SE OT        RE   A 100506      100306  090106  093006
 THOMAS HON   OR OT        NA   A 100506      100306  090106  093006





 Message
```

MAFI Prior Month 09-06

- Check the MAFI screen
- Enter “y” to confirm if correct

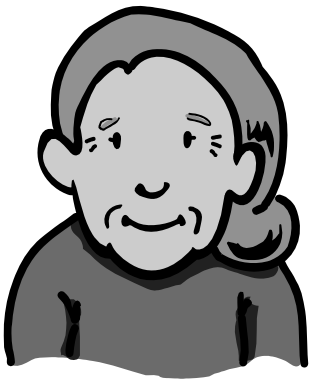
```
FINALIZE              MA FINANCIAL ELIGIBILITY - MAFI              MAFI    A
  Month 09 06                    0601   10 05 06
 AU ID 106514343   Prog MA   Prog Type D        Med COA L01

 Resources                          Income Test Continued
   Resource Limit        101540.00   Allocated Income           .00
   Total Resources         5250.00   Gross Unearned Income  1700.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income    1700.00   Net Unearned Income    1700.00
   Medicare Premium                  Gross Earned Income        .00
   Protected Income        1700.00   Earned Inc Deductions      .00
   Person Needs Allowance    00.00   Net Earned Income          .00
   Diversion Amount          00.00   Net Income             1700.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

FPME

- Check that 09-06 benefit month is now "**A**" for active, and its disposition is "**Finalized by worker**".
- Finalize the prior month by entering "**Y**" and press ENTER.

```
UPDATE               FINALIZE PRIOR MEDICAID - FPME                 FPME


 HOH Name THOMAS     HONG                  Client ID 106510738
 AU ID  106514343

 Finalize Y

 Bnft     Status     Med     Spenddown     Disposition Status
 Month               COA      Amount


 07 06
 08 06
 09 06       A       L01                   FINALIZED BY WORKER
```

MARY ELLEN SMITH
Nursing Home Initial Application



Recall that Ms. Smith was registered during the Screening and Registration module. Refer to her application in the case record.

Your Assignment:

- Answer the policy questions relating to Ms. Smith.
- Assume that you interviewed Ms. Smith's daughter by telephone. Prior to entering the nursing home, Ms. Smith lived in her home at 252 Lake Street, Pearson GA 31513 from June 1973 to October 2006. She owns her home.
- Review the verification that is available to you.
- Prepare a verification checklist to send to Ms. Smith.
- Complete the Medicaid Cap and Patient Liability budget for this case.
- Complete the Interview (O) process independently. Remember to document using the Documentation Standards.
- Review the verification received, complete the Burial Exclusion Form, then process and finalize the case independently.
- Compare your MAFI screens to the ones in your participant guide.

Ms. Smith is an "independent" case. The trainers will not go through screens with you. Ask trainers for assistance if needed. You will have one hour to complete your case.

POLICY QUESTIONS

- **For what type of Medicaid is the AR applying (remember the CMD order of eligibility)?**
- **What is the SOP for this application?**
- **What type of interview is required?**
- **What mandatory forms must be completed?**
- **How will categorical relationship be verified for this AR?**
- **How will enumeration be verified?**
- **Does the AR need to apply for any other benefits?**
- **What are the AR's countable resources?**
- **How will each resource be verified?**
- **What is the AR's countable income?**
- **How will each type of income be verified?**

COMPLETE THE VERIFICATION CHECKLIST FOR THIS AR.

- **What information will be verified directly from the source (ie property search)?**

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between _____AM and _____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

BURIAL EXCLUSION

☐FBR or☐ NON-FBR
(Check Which)

Complete form for each A/R & spouse, as needed. Application/Review date: _____

BURIAL CONTRACT:

a. Name of Funeral Home: _____ Phone #: _____

b. Contract owned by A/R or Spouse? ☐ Yes ☐ No If no, who owns: _____

c. Is contract itemized? ☐ Yes ☐ No

d. Is contract designated for A/R or spouse? ☐ Yes ☐ No

e. Is contract paid in full? ☐Yes ☐ No If yes, list purchase price $_____ Date: _____

f. Determine the value of the paid in full burial space items. List below:

Burial Space Item	$ Value
Total	

g. Subtract $ amount in F from $ amount in E.

As of: E - F = Countable non-burial space amt.

Date _____ $ _____ - _____ = $ _____

IF	THEN
Contract owned by other than A/R or Deemor,	Do not count as a resource. Investigate for possible transfer of assets. Section 2342.
Contract owned by A/R/Deemor & is irrevocable,	Treat same as revocable contract.
Contract owned by A/R/Deemor, is Non-itemized, revocable & for family member,	Count as a resource the full "Current Refund Value" of the contract. See above.
Contract owned by A/R/Deemor, is itemized, revocable & paid in full,	Count the "Countable non-burial space amt." shown above.
Contract owned by A/R/Deemor, is itemized, revocable & **NOT** paid in full & is not designated or for non-family member,	Count the refund value of burial space items for those non family members.
Contract Not paid in full,	The burial space items that are **PAID** for may be designated for burial. Any PAID for NON burial space items are a countable resource.

DHR 05/09

BURIAL EXCLUSION DOCUMENTATION

BURIAL FUNDS: Attach copy of Form 985. If totally excluded, do not count interest accrued.

LIFE INSURANCE POLICIES: Attach copy of "Record of Life Insurance Policies".

h. From Form 985, enter value of any **Burial Fund(s)**:

Designated Value:	Value + accrued interest (Use only if unable to use for Burial Exclusion allowance.)
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____ Total	$ _____ Total

NOTE: If part of a burial fund is not to be excluded, compute the percentage of the countable portion to use in subsequent reviews. Use the same procedure as in e, f & g of Burial Contracts.

i. From **"Record of Insurance Policies"**, enter Face Value (FV) and Cash Surrender Value (CSV) of each policy. Use CSV only if unable to use for Burial Exclusion allowance.

Documentation:

FV	CSV
$	$
$	$
$	$
$	$
$	$
$	$

Totals:

j. **Burial Assets**

Total of Burial Contracts: (g.) $ _____

Total of Burial Funds: $ _____

Total of FV of Life Insurance: $ _____

Total Burial Assets: $ _____

k. **Burial Exclusion Allowance:** _____

Contracts used for Burial Exc. $ _____

Burial Funds used for Burial Exc.$ _____

FV of Life Ins. used for Bur. Exc. $ _____

Actual amt. designated for Burial $ _____

(Total should be = or < than $1500/$10,000)

l. **Total to count toward resource** limit **of A/R:** (Use **only** if **all** burial assets are not exempt.)

Burial Contract (g): _____

Burial Funds (2nd column h. above) _____

CSV of Life Insurance (i. above): _____

Total countable burial assets: _____

Does this amount combined with other assets exceed the resource limit?

Yes ☐ No ☐

m. Enter the total amount in k. in SUCCESS, RES1, as a "burial contract" (BC) to be excluded. Count those not excluded for burial as a countable resource (l. above). Enter total in l. above in SUCCESS, RES3, as other countable resource (OC), and document case on REMA.

Add text to the notice if A/R's AU is closed/denied due to excess burial assets: "Due to burial policy changes, your resources exceed the allowable limit. Manual reference Sections 2311, 2312, 2323."

MEDICAID CAP MAO BUDGET SHEET

☐ INITIAL DETERMINATION ☐ REDETERMINATION ☐ SPECIAL REVIEW DATE _____

NAME OF APPLICANT(S) OR RECIPIENT(S)	CASE NUMBER(S)
1.	
2.	

A. UNEARNED INCOME (U.I.)	A/R in MTF	SPOUSE in MTF	B. EARNED INCOME (E.I.)	A/R in MTF	SPOUSE in MTF
1.			1.		
2.			2.		
3.			3.		
4.			4. Gross Earned Income		
5. Subtotal					

c. ELIGIBILITY DETERMINATION	INDIVIDUAL IN MTF		INDIVIDUAL IN MTF	
1. Gross Medicaid CAP				
2. Subtract Adjusted Gross U.I. (A 5)				
3. Subtotal				
4. Subtract Gross E.I. (B 4)				
5. SURPLUS/DEFICIT				

ADDITIONAL INFORMATION / COMPUTATION SPACE

Georgia Department of Human Resources

Patient Liability Budget Sheet

AU Name: _____ AU Number: _____ Date: _____

Section A – Diversion of Income to Dependents	Month _____	Month _____	Month _____
1. Enter Diversion Standard (FBR, SON, CSMNS, DFMNS).			
2. Subtract Spouse/Dependent's ADJUSTED GROSS Income, including ISM, after allowing Mandatory Deductions.			
3. TOTAL DIVERTED INCOME (Line 1 minus Line 2)			
Section B – Incurred Medical Expenses (IMEs)			
1. Enter Insurance Premium			
2. Enter Other IMEs			
3. Enter Other IMEs			
4. TOTAL IMEs (Total of Lines 1 through 3)			
Section C – Patient Liability Budget			
1. Enter recipient's SSI Income (month of admission only)			
2. Enter recipient's ADJUSTED GROSS Unearned and Earned Income after allowing mandatory deductions.			
3. Subtotal (Line 1 plus Line 2)			
4. Subtract Medicare Premium if applicable (through month after month of Medicaid approval)			
5. Subtotal (Line 3 minus Line 4)			
6. Subtract Protected income (All, ½, 0). (Admission/Discharge Date _____).			
7. Subtotal (Line 5 minus Line 6)			
8. Subtract Personal Needs Allowance.			
9. Subtotal (Line 7 minus Line 8)			
10. Subtract Diverted Income (From Line A.3)			
11. Subtotal (Line 9 minus Line 10)			
12. Subtract IMEs (from Line B.4 or Averaged IMEs)			
13. Patient Liability (Line 13 minus Line 14)			

Form 968 (R. 09/04)

INST (SEE DMA-59)

```
INTERVIEW                        INSTITUTION - INST                      INST 01
 Month 11 06                     A137   10 05 06                        01

 Client Name MARY         SMITH                  Client ID 106594364


 D Inst   Prov    Admission Discharge   NH     LOC  V  Payment   -- Payment --
   Type    ID       Date      Date    Perdiem  Auth    Auth Date Term DT   Rsn
    NH  00083047A  10 03 06           ?         S   OT 10 03 06  020220     L

 Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
 Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V
                                                            H     88.50   BE

   Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
 Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met                Ind
                                                   Y     NH  401.9      N
                                                 More Institutions
 Message
          15-lett 16-pmen                                          24-del
```

Process/Finalize Application Months

ELIG 10-06

```
FINALIZE            FINANCIAL ELIGIBILITY RESULTS – ELIG                ELIG 01    A
Month 10 06                                                                01

AU ID  238064015     Prog MA     Prog Type D    Med COA L01
Confirm  Y

  AU    AU Status   AU Stat      Appl    Begin    Pd Thru     -----Penalty-----
 Stat    Reasons     Date        Date     Date     Date         Type     End Date
   A                100506      100406  100106
------------------------------------------------------------------------------------------
-----------------------------------------------
First   Last     Rel V Mand Finl    --Stat--    Rsn    Appl     Begin    Pd Thru    Penalty
Name    Name           Incl Resp     Date              Date     Date     Date       T   Date
MAR     SMI      SE  OT      RE     A  100506        100406   100106

Message
```

MAFI 10-06

```
FINALIZE                          MA FINANCIAL ELIGIBILITY – MAFI               MAFI    A
Month  10 06                                 0601     10  05 06
AU ID  238064015     Prog  MA     Prog Type  D          Med COA  L01

Resources                                       Income Test Continued
Resource Limit                  2000.00           Allocated Income                   .00
Total Resources                  250.00           Gross Unearned Income          1340.00
Patient Liability/ Cost Share                     General Inc Deduction              .00
   Pat Liability Income         1340.00           Net Unearned Income            1340.00
   Medicare Premium               88.50           Gross Earned Income                .00
   Protected Income              625.75           Earned Income Deductions           .00
   Person Needs Allowance         50.00           Net Earned Income                  .00
   Diversion Amount                 .00           Net Income                     1340.00
   IME Amount                       .00           Income Limit                   1809.00
   Pat Liab/ Cost Shar Amt       575.00           Spenddown Amount
Income Test                                       Medical Expense Amt
   Gross Deemer Income              .00           Net Spenddown Amount

Bnft Eff Date  100506        Bnft Confirm  Y     Reasons                   Recon Ind  N
Notice Type  0003               Waive Timely Ntc      Period          Notice Override
Review Begin Date  10 06        Review End Date  10 07                Strat 1
Message

 13-note
```

ELIG 11-06

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 11 06                                                           01

 AU ID 235064015    Prog MA    Prog Type D   Med COA L01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  D                  100506   100406   100106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 MARY   SMI   SE OT        RE   A 100506      100406  100106



 Message
```

MAFI 11-06

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 11 06                    0601   10 05 06
 AU ID 238064015   Prog MA   Prog Type D        Med COA L01

 Resources                          Income Test Continued
   Resource Limit          2000.00   Allocated Income           .00
   Total Resources          250.00   Gross Unearned Income  1340.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income        .00   Net Unearned Income    1340.00
   Medicare Premium        1340.00   Gross Earned Income        .00
   Protected Income          88.50   Earned Inc Deductions      .00
   Person Needs Allowance    50.00   Net Earned Income          .00
   Diversion Amount            .00   Net Income             1340.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt  1201.00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

MARY HARVEY

CCSP Initial Application

Recall that Ms. Harvey was registered during the Screening and Registration module. Refer to her application in the case record.

Your Assignment:

- Complete the policy questions related to this case.
- Assume that you interviewed Ms. Harvey about her situation.
- Review the verification that is available to you.
- Prepare a verification checklist to send to Ms. Harvey.
- Complete the Medicaid Cap budget and the Patient Liability budget.
- Complete the Interview (O) process:
    - You will complete most of the screens independently. The coding of the INST screen will be new, so stop at the INST screen. The trainers will walk you through this screen.
    - Stop at the UINC Screen. Trainers will walk you through how to code this screen for AUs with a QIT.
- Review the verification received, complete the Burial Exclusion Form, then process and finalize the case.

Compare your MAFI screens to the ones in your Participant Guide.

Note that Ms. Harvey will need the prior month of September. Authorize this month independently. Remember Ms. Harvey did not receive VA benefits for September 2006.

POLICY QUESTIONS

- **For what type of Medicaid is the AR applying (remember the CMD order of eligibility)?**
- **What is the SOP for this application?**
- **What type of interview is required?**
- **What mandatory forms must be completed?**
- **How will categorical relationship be verified for this AR?**
- **How will enumeration be verified?**
- **Does the AR need to apply for any other benefits?**
- **What are the AR's countable resources?**
- **How will each resource be verified?**
- **What is the AR's countable income?**
- **How will each type of income be verified?**

COMPLETE THE VERIFICATION CHECKLIST FOR THIS AR.

- **What information will be verified directly from the source (ie property search)?**

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between _____AM and _____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

BURIAL EXCLUSION
☐FBR or☐ NON-FBR
(Check Which)

Complete form for each A/R & spouse, as needed. Application/Review date: _____

BURIAL CONTRACT:

a. Name of Funeral Home: _____ Phone #: _____

b. Contract owned by A/R or Spouse? ☐ Yes ☐ No If no, who owns: _____

c. Is contract itemized? ☐ Yes ☐ No

d. Is contract designated for A/R or spouse? ☐ Yes ☐ No

e. Is contract paid in full? ☐Yes ☐ No If yes, list purchase price $_____ Date: _____

f. Determine the value of the paid in full burial space items. List below:

Burial Space Item	$ Value
Total	

g. Subtract $ amount in F from $ amount in E.

As of: E - F = Countable non-burial space amt.

Date _____ $ _____ - _____ = $ _____

IF	THEN
Contract owned by other than A/R or Deemor,	Do not count as a resource. Investigate for possible transfer of assets. Section 2342.
Contract owned by A/R/Deemor & is irrevocable,	Treat same as revocable contract.
Contract owned by A/R/Deemor, is Non-itemized, revocable & for family member,	Count as a resource the full "Current Refund Value" of the contract. See above.
Contract owned by A/R/Deemor, is itemized, revocable & paid in full,	Count the "Countable non-burial space amt." shown above.
Contract owned by A/R/Deemor, is itemized, revocable & **NOT** paid in full & is not designated or for non-family member,	Count the refund value of burial space items for those non family members.
Contract Not paid in full,	The burial space items that are **PAID** for may be designated for burial. Any PAID for NON burial space items are a countable resource.

DHR 05/09

BURIAL EXCLUSION DOCUMENTATION

BURIAL FUNDS: Attach copy of Form 985. If totally excluded, do not count interest accrued.

LIFE INSURANCE POLICIES: Attach copy of "Record of Life Insurance Policies".

h. From Form 985, enter value of any **Burial Fund(s)**:

Designated Value:	Value + accrued interest (Use only if unable to use for Burial Exclusion allowance.)
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____ Total	$ _____ Total

NOTE: If part of a burial fund is not to be excluded, compute the percentage of the countable portion to use in subsequent reviews. Use the same procedure as in e, f & g of Burial Contracts.

i. From **"Record of Insurance Policies"**, enter Face Value (FV) and Cash Surrender Value (CSV) of each policy. Use CSV only if unable to use for Burial Exclusion allowance.

Documentation:

FV	CSV
$	$
$	$
$	$
$	$
$	$
$	$

Totals:

j. **Burial Assets**

Total of Burial Contracts: (g.) $ _____

Total of Burial Funds: $ _____

Total of FV of Life Insurance: $ _____

Total Burial Assets: $ _____

k. **Burial Exclusion Allowance:** _____

Contracts used for Burial Exc. $ _____

Burial Funds used for Burial Exc.$ _____

FV of Life Ins. used for Bur. Exc. $ _____

Actual amt. designated for Burial $ _____

(Total should be = or < than $1500/$10,000)

l. **Total to count toward resource** limit **of A/R:** (Use **only** if **all** burial assets are not exempt.)

Burial Contract (g): _____

Burial Funds (2nd column h. above) _____

CSV of Life Insurance (i. above): _____

Total countable burial assets: _____

Does this amount combined with other assets exceed the resource limit?

Yes ☐ No ☐

m. Enter the total amount in k. in SUCCESS, RES1, as a "burial contract" (BC) to be excluded. Count those not excluded for burial as a countable resource (l. above). Enter total in l. above in SUCCESS, RES3, as other countable resource (OC), and document case on REMA.

Add text to the notice if A/R's AU is closed/denied due to excess burial assets: "Due to burial policy changes, your resources exceed the allowable limit. Manual reference Sections 2311, 2312, 2323."

MEDICAID CAP MAO BUDGET SHEET

☐ INITIAL DETERMINATION ☐ REDETERMINATION ☐ SPECIAL REVIEW DATE _____

NAME OF APPLICANT(S) OR RECIPIENT(S)	CASE NUMBER(S)
1.	
2.	

A. UNEARNED INCOME (U.I.)	A/R in MTF	SPOUSE in MTF	B. EARNED INCOME (E.I.)	A/R in MTF	SPOUSE in MTF
1.			1.		
2.			2.		
3.			3.		
4.			4. Gross Earned Income		
5. Subtotal					

c. ELIGIBILITY DETERMINATION	INDIVIDUAL IN MTF		INDIVIDUAL IN MTF	
1. Gross Medicaid CAP				
2. Subtract Adjusted Gross U.I. (A 5)				
3. Subtotal				
4. Subtract Gross E.I. (B 4)				
5. SURPLUS/DEFICIT				

ADDITIONAL INFORMATION / COMPUTATION SPACE

QUALIFIED INCOME TRUST (QIT) WORKSHEET

Income Source	Monthly **Gross** Amount
Social Security	_____
State Retirement	_____
V.A. Pension	_____
Other Pension	_____
Interest, Dividends	_____
Annuity	_____
Other	_____
Total Monthly Income	_____
Current Medicaid Cap - $1.00	- _____
Amount Over Cap*	_____

*THIS IS THE MINIMUM AMOUNT THAT MUST BE DEPOSITED INTO THE QIT ACCOUNT EACH MONTH. **HOWEVER, WE STRONGLY RECOMMEND THAT ALL OF THE INCOME BE DEPOSITED INTO THE QIT EACH MONTH.** THIS WILL REDUCE THE PROBABILITY OF ERRORS. **REMEMBER, FAILURE TO PROPERLY AND TIMELY FUND THE QIT WILL RESULT IN A LOSS OF ELIGIBILITY FOR THAT MONTH.**

Allowable QIT Disbursements	Amount
Patient Liability/Cost Share	$
Personal Needs Allowance	$
Diversion to Spouse/Dependent Family Member	$
Incurred Medical Expense(s)	Any Medical Expense not covered by Medicaid.

Georgia Qualified Income Trust Worksheet 04/05

MEDICAID CAP MAO BUDGET SHEET

☐ INITIAL DETERMINATION ☐ REDETERMINATION ☐ SPECIAL REVIEW DATE _____

NAME OF APPLICANT(S) OR RECIPIENT(S)	CASE NUMBER(S)
1.	
2.	

A. UNEARNED INCOME (U.I.)	A/R in MTF	SPOUSE in MTF	B. EARNED INCOME (E.I.)	A/R in MTF	SPOUSE in MTF
1.			1.		
2.			2.		
3.			3.		
4.			4. Gross Earned Income		
5. Subtotal					

c. ELIGIBILITY DETERMINATION	INDIVIDUAL IN MTF		INDIVIDUAL IN MTF	
1. Gross Medicaid CAP				
2. Subtract Adjusted Gross U.I. (A 5)				
3. Subtotal				
4. Subtract Gross E.I. (B 4)				
5. SURPLUS/DEFICIT				

ADDITIONAL INFORMATION / COMPUTATION SPACE

Georgia Department of Human Resources

Patient Liability Budget Sheet

AU Name: _____ AU Number: _____ Date: _____

Section A – Diversion of Income to Dependents	Month _____	Month _____	Month _____
1. Enter Diversion Standard (FBR, SON, CSMNS, DFMNS).			
2. Subtract Spouse/Dependent's ADJUSTED GROSS Income, including ISM, after allowing Mandatory Deductions.			
3. TOTAL DIVERTED INCOME (Line 1 minus Line 2)			
Section B – Incurred Medical Expenses (IMEs)			
1. Enter Insurance Premium			
2. Enter Other IMEs			
3. Enter Other IMEs			
4. TOTAL IMEs (Total of Lines 1 through 3)			
Section C – Patient Liability Budget			
1. Enter recipient's SSI Income (month of admission only)			
2. Enter recipient's ADJUSTED GROSS Unearned and Earned Income after allowing mandatory deductions.			
3. Subtotal (Line 1 plus Line 2)			
4. Subtract Medicare Premium if applicable (through month after month of Medicaid approval)			
5. Subtotal (Line 3 minus Line 4)			
6. Subtract Protected income (All, ½, 0). (Admission/Discharge Date _____).			
7. Subtotal (Line 5 minus Line 6)			
8. Subtract Personal Needs Allowance.			
9. Subtotal (Line 7 minus Line 8)			
10. Subtract Diverted Income (From Line A.3)			
11. Subtotal (Line 9 minus Line 10)			
12. Subtract IMEs (from Line B.4 or Averaged IMEs)			
13. Patient Liability (Line 13 minus Line 14)			

Form 968 (R. 09/04)

INST

- Patent Liab Amount field must be completed for all QIT cases
- Enter the total Gross income the client receives before establishing a QIT account

```
INTERVIEW                        INSTITUTION - INST                    INST 01
 Month 11 06                     A137   10 05 06                      01

 Client Name MARY           HARVEY                Client ID XXXXXXXXX


 D Inst   Prov    Admission Discharge   NH     LOC  V  Payment   -- Payment --
   Type    ID       Date      Date    Perdiem  Auth    Auth Date Term DT   Rsn
    WV             090906                ?      C   CC            100107     L

 Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
 Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V
                                2130.00 OT                     H   88.50     BE

   Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
 Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met             Ind
            C   09 12 06                            Y      CF         N
                                                         More Institutions
 Message

          15-lett 16-pmen                                          24-del
```

UINC

- Enter the RSDI amount
- Put a Y in the More field to get a second UINC screen

```
INTERVIEW                  UNEARNED INCOME - UINC                  UINC 01
  Month 11 06                                                        00

 Client Name MARY           HARVEY                Client ID XXXXXXXXX

 Do you have any of the following: RSDI, alimony, direct child support,
 contributions, VA, workers compensation, unemployment, sick/disability benfits,
 pension, railroad retirement, any other retirement, rent, interest, annuities,
 dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay
 SA             MO    22222XXXXA

 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V
 10 01 06  1230.00  BX


                                  Client Potentially Elig For Other Benefits?
                                                                   More Y
  Appl Type     Stat    Date                 Appl Type     Stat    Date
  Message

               15-lett                       16-uvnc           23-alau  24-del
```

UNIC

- Enter VA Income amount
- This amount was placed in the QIT account and will be deducted from the gross income in the Eligibility budget.
- Complete the Ded, Ded Amt, and V fields:
  - Ded (PF1 for code)
  - Enter amount placed in QIT account
  - V (PFI for code)
- Document according to Documentation Standards

```
INTERVIEW                    UNEARNED INCOME - UINC                    UINC 01
  Month 11 06                                                            01

 Client Name MARY            HARVEY                Client ID XXXXXXXXX

 Do you have any of the following: RSDI, alimony, direct child support,
 contributions, VA, workers compensation, unemployment, sick/disability benfits,
 pension, railroad retirement, any other retirement, rent, interest, annuities,
 dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay
 VA             MO   23222XXXXA   OT    900.00 OT

 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V
 10 01 06  900.00  LE


                                 Client Potentially Elig For Other Benefits?
                                                                       More
  Appl Type     Stat    Date                 Appl Type     Stat    Date
  Message

               15-lett                        16-uvnc           23-alau  24-del
```

Process/Finalize Application Months

ELIG

- Enter Y in the confirm field

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 10 06                                                           01

 AU ID XXXXXXXXX    Prog MA    Prog Type D   Med COA W01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   100406   100106
 ---------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 MARY   HAR   SE OT        RE   A 100506      100406  100106



 Message
```

MAFI

- Enter Y in the confirm field

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 10 06                    0601   10 05 06
 AU ID XXXXXXXXX   Prog MA   Prog Type D        Med COA W01

 Resources                          Income Test Continued
   Resource Limit          2000.00   Allocated Income           .00
   Total Resources         1575.00   Gross Unearned Income  1230.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income    2130.00   Net Unearned Income    1230.00
   Medicare Premium          88.50   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance   603.00   Net Earned Income          .00
   Diversion Amount          00.00   Net Income             1230.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt  1438.00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

Process/Finalize Application Months

ELIG

- Enter Y in the confirm field

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 11 06                                                           01

 AU ID XXXXXXXXX    Prog MA    Prog Type D   Med COA W01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   100406   100106
 ---------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 MARY   HAR   SE OT        RE   A 100506      100406  100106



 Message
```

MAFI

- Enter Y in the confirm field

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 11 06                    0601   10 05 06
 AU ID 238064015   Prog MA   Prog Type D        Med COA W01

 Resources                          Income Test Continued
   Resource Limit          2000.00   Allocated Income           .00
   Total Resources         1575.00   Gross Unearned Income  1230.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income    2130.00   Net Unearned Income    1230.00
   Medicare Premium          88.50   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance   603.00   Net Earned Income          .00
   Diversion Amount          00.00   Net Income             1230.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt  1438.00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

UINC PRIOR MONTH 09-06

- VA income must be deleted; VA income begins 10-2006
- Enter “Y” in the DEL field and press PF24

```
INTERVIEW                  UNEARNED INCOME - UINC                  UINC 01
  Month 09 06                                                        01

 Client Name MARY          HARVEY                Client ID 106510738

 Do you have any of the following: RSDI, alimony, direct child support,
 contributions, VA, workers compensation, unemployment, sick/disability benfits,
 pension, railroad retirement, any other retirement, rent, interest, annuities,
 dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay
 VA       Y    MO   23222XXXX      OT    900.00  OT

 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V
 10 01 06   900.00  LE


                                 Client Potentially Elig For Other Benefits?
                                                                      More
  Appl Type     Stat    Date                 Appl Type     Stat    Date
  Message

               15-lett                        16-uvnc           23-alau  24-del
```

INST PRIOR MONTH 09-06

- Remove patient liability income amount of $2130 and verification code

```
INTERVIEW                        INSTITUTION - INST                     INST 01
 Month 09 06                     A137   10 05 06                        01

 Client Name MARY           HARVEY                Client ID 106510738


 D Inst   Prov    Admission Discharge   NH     LOC  V  Payment   -- Payment --
   Type    ID       Date      Date    Perdiem  Auth    Auth Date Term DT   Rsn
    WV             090906                ?      C   CC           100107     L

 Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
 Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V
                                                           H   88.50     BE

   Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
 Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met             Ind
             C   09 12 06                            Y      CF         N
                                                        More Institutions
 Message

         15-lett 16-pmen                                            24-del
```

ELIG PRIOR MONTH 09-06

- Enter Y in the confirm field

```
FINALIZE          NON-FINANCIAL ELIGIBILITY RESULTS - ELIG         ELIG    A
Month 09 06                                                         01

 AU ID XXXXXXXXX    Prog MA    Prog Type D   Med COA W01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                 100506   100406   090106   090306
 -------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date         Date   Date   Date    T  Date
 MARY   HAR   SE OT        RE   A 100506      100406  090106 093006







 Message
```

MAFI PRIOR MONTH 09-06

- Enter Y in the confirm field

```
FINALIZE             MA FINANCIAL ELIGIBILITY - MAFI              MAFI    A
  Month 09 06                          0601   10 05 06
 AU ID XXXXXXXXX   Prog MA   Prog Type D       Med COA W01

 Resources                         Income Test Continued
   Resource Limit          2000.00   Allocated Income            .00
   Total Resources         1575.00   Gross Unearned Income  1230.00
 Patient Liability/Cost Share        General Inc Deduction       .00
   Pat Liability Income    1230.00   Net Unearned Income    1230.00
   Medicare Premium          88.50   Gross Earned Income         .00
   Protected Income         570.75   Earned Inc Deductions       .00
   Person Needs Allowance   603.00   Net Earned Income           .00
   Diversion Amount            .00   Net Income             1230.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                Recon Ind N
 Notice Type 0003          Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

MARVIN FRANKLIN
Hospice Initial Application

Recall that Mr. Franklin was registered during the Screening and Registration module. Refer to his application in the case record.

Your Assignment:

- Complete the policy questions related to this application.
- Assume that you interviewed Mr. George Franklin about his father's situation.
- Review any verification that is available to you.
- Prepare a verification checklist to send to Mr. Franklin.
- Complete the Medicaid Cap budget.
- Complete the Interview (O) process:
    - You will complete most of the screens independently. Code the Hospice provider as an AREP. The coding of the Disability/Incapacity fields on the DEM2 screen will be new, so stop at the DEM2 screen. Review the instructions provided on PG-110 and then complete the screen.
    - The coding of the INST screen will be new, so stop at the INST screen. Review the instructions provided and then complete the screen. Ask trainers for assistance if needed.
- Review the verification received, complete the Burial Exclusion Form, then process and finalize the case.

Compare your MAFI screens to the ones in your participant guide.

POLICY QUESTIONS

- **For what type of Medicaid is the AR applying (remember the CMD order of eligibility)?**
- **What is the SOP for this application?**
- **What type of interview is required?**
- **What mandatory forms must be completed?**
- **How will categorical relationship be verified for this AR?**
- **How will enumeration be verified?**
- **Does the AR need to apply for any other benefits?**
- **What are the AR's countable resources?**
- **How will each resource be verified?**
- **What is the AR's countable income?**
- **How will each type of income be verified?**

COMPLETE THE VERIFICATION CHECKLIST FOR THIS AR.

- **What information will be verified directly from the source (ie property search)?**

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between _____AM and _____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

BURIAL EXCLUSION
☐FBR or☐ NON-FBR
(Check Which)

Complete form for each A/R & spouse, as needed. Application/Review date: _____

BURIAL CONTRACT:

a. Name of Funeral Home: _____ Phone #: _____

b. Contract owned by A/R or Spouse? ☐ Yes ☐ No If no, who owns: _____

c. Is contract itemized? ☐ Yes ☐ No

d. Is contract designated for A/R or spouse? ☐ Yes ☐ No

e. Is contract paid in full? ☐Yes ☐ No If yes, list purchase price $_____ Date: _____

f. Determine the value of the paid in full burial space items. List below:

Burial Space Item	$ Value
Total	

g. Subtract $ amount in F from $ amount in E.

As of: E - F = Countable non-burial space amt.

Date _____ $ _____ - _____ = $ _____

IF	THEN
Contract owned by other than A/R or Deemor,	Do not count as a resource. Investigate for possible transfer of assets. Section 2342.
Contract owned by A/R/Deemor & is irrevocable,	Treat same as revocable contract.
Contract owned by A/R/Deemor, is Non-itemized, revocable & for family member,	Count as a resource the full "Current Refund Value" of the contract. See above.
Contract owned by A/R/Deemor, is itemized, revocable & paid in full,	Count the "Countable non-burial space amt." shown above.
Contract owned by A/R/Deemor, is itemized, revocable & **NOT** paid in full & is not designated or for non-family member,	Count the refund value of burial space items for those non family members.
Contract Not paid in full,	The burial space items that are **PAID** for may be designated for burial. Any PAID for NON burial space items are a countable resource.

DHR 05/09

BURIAL EXCLUSION DOCUMENTATION

BURIAL FUNDS: Attach copy of Form 985. If totally excluded, do not count interest accrued.

LIFE INSURANCE POLICIES: Attach copy of "Record of Life Insurance Policies".

h. From Form 985, enter value of any **Burial Fund(s)**:

Designated Value:	Value + accrued interest (Use only if unable to use for Burial Exclusion allowance.)
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____	$ _____
$ _____ Total	$ _____ Total

NOTE: If part of a burial fund is not to be excluded, compute the percentage of the countable portion to use in subsequent reviews. Use the same procedure as in e, f & g of Burial Contracts.

i. From **"Record of Insurance Policies"**, enter Face Value (FV) and Cash Surrender Value (CSV) of each policy. Use CSV only if unable to use for Burial Exclusion allowance.
Documentation:

FV	CSV
$	$
$	$
$	$
$	$
$	$
$	$

Totals:

j. **Burial Assets**

Total of Burial Contracts: (g.) $ _____
Total of Burial Funds: $ _____
Total of FV of Life Insurance: $ _____
Total Burial Assets: $ _____

k. **Burial Exclusion Allowance:** _____
Contracts used for Burial Exc. $ _____
Burial Funds used for Burial Exc.$ _____
FV of Life Ins. used for Bur. Exc. $ _____
Actual amt. designated for Burial $ _____
(Total should be = or < than $1500/$10,000)

l. **Total to count toward resource** limit **of A/R:** (Use **only** if **all** burial assets are not exempt.)
Burial Contract (g): _____
Burial Funds (2nd column h. above) _____
CSV of Life Insurance (i. above): _____
Total countable burial assets: _____

Does this amount combined with other assets exceed the resource limit?
Yes ☐ No ☐

m. Enter the total amount in k. in SUCCESS, RES1, as a "burial contract" (BC) to be excluded. Count those not excluded for burial as a countable resource (l. above). Enter total in l. above in SUCCESS, RES3, as other countable resource (OC), and document case on REMA.
Add text to the notice if A/R's AU is closed/denied due to excess burial assets: "Due to burial policy changes, your resources exceed the allowable limit. Manual reference Sections 2311, 2312, 2323."

MEDICAID CAP MAO BUDGET SHEET

☐ INITIAL DETERMINATION ☐ REDETERMINATION ☐ SPECIAL REVIEW DATE _____

NAME OF APPLICANT(S) OR RECIPIENT(S)	CASE NUMBER(S)
1.	
2.	

A. UNEARNED INCOME (U.I.)	A/R in MTF	SPOUSE in MTF	B. EARNED INCOME (E.I.)	A/R in MTF	SPOUSE in MTF
1.			1.		
2.			2.		
3.			3.		
4.			4. Gross Earned Income		
5. Subtotal					

c. ELIGIBILITY DETERMINATION	INDIVIDUAL IN MTF		INDIVIDUAL IN MTF	
1. Gross Medicaid CAP				
2. Subtract Adjusted Gross U.I. (A 5)				
3. Subtotal				
4. Subtract Gross E.I. (B 4)				
5. SURPLUS/DEFICIT				

ADDITIONAL INFORMATION / COMPUTATION SPACE

DEM2

- Press PF1 for code to complete the Disab type and approval source
- Use approval source (ex: Bendex) to get the disability date

```
INTERVIEW                CLIENT DEMOGRAPHIC 2 - DEM2              DEM2 01
  Month 11 06                    0002   10 05 06

 Client Name MARVIN         FRANKLIN              Client ID XXXXXXXXX

 Citiz V  Student V  High Grade V Striker ---Immunization --  Law -Health Chk -
          Stat      Completed     Stat   Curr GCse Due Dt   Brkr Ref   Date
   C  OT                          N

 TPL  TPL   V  ------ Medicare -----    ------  Disability / Incapacity ------
      Coop     Entitlmnt   Claim Num    Disab  Approval Begin Date  End Date
                                        Type   Source   (MM YYYY)   (MM YYYY)
  N    C    CS  Y       55555XXXXA   O      RS     032002

 Joint  Vet   Military    Death   TANF Cap Parent ------ TANF Cap Child ----
 SSI/FS Stat  Serv Num    Date     Ctr  End Date  Parnt ID Rcv Mo Cncpt GCse
        N

 Non-Custodial Parent?     V


 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
              15-lett                                    22-tpl 23-alau
```

INST

- Complete the INST screen
- Remember if the Inst Type highlights in red, you must complete the HCB Waiver field
- Note the Payment Termination Date

```
INTERVIEW                        INSTITUTION - INST                      INST 01
 Month 11 06                    A137   10 05 06                       01

 Client Name MARVIN         FRANKLIN              Client ID XXXXXXXXX

 D Inst   Prov    Admission Discharge   NH     LOC  V  Payment   -- Payment --
   Type    ID       Date      Date    Perdiem  Auth    Auth Date Term DT   Rsn
    HP            09 15 06               ?     H    CF           12 14 06   L

 Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
 Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V


   Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
 Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met             Ind
             H     09 15 06                          Y     CF           N
                                                   More Institutions
 Message

          15-lett 16-pmen                                          24-del
```

Process/Finalize Application Months

ELIG 09-06

- Enter Y in the confirm field

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 09 06                                                           01

 AU ID XXXXXXXXX    Prog MA    Prog Type D   Med COA W01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   093006   090106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 MARVIN FRA   SE OT        RE   A 100506      093006  090106



 Message
```

MAFI 09-06

- Enter Y in the confirm field

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 09 06                    0601   10 05 06
 AU ID XXXXXXXXX   Prog MA   Prog Type D        Med COA W01

 Resources                          Income Test Continued
   Resource Limit          2000.00   Allocated Income           .00
   Total Resources          475.00   Gross Unearned Income  1365.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income        .00   Net Unearned Income    1365.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income             1365.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

ELIG 10-06

- Enter Y in the confirm field

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 10 06                                                           01

 AU ID XXXXXXXXX    Prog MA    Prog Type D   Med COA W01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   093006   090106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 MARVIN FRA   SE OT        RE   A 100506      093006  090106









 Message
```

MAFI 10-06

- Enter Y in the confirm field

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 10 06                    0601   10 05 06
 AU ID XXXXXXXXX   Prog MA   Prog Type D        Med COA W01

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   Total Resources          475.00   Gross Unearned Income  1365.00
 Patient Liability/Cost Share        General Inc Deduction      .00
   Pat Liability Income        .00   Net Unearned Income    1365.00
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   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income             1365.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

ELIG 11-06

- Enter Y in the confirm field

```
FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 11 06                                                           01

 AU ID XXXXXXXXX    Prog MA    Prog Type D   Med COA W01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100506   093006   090106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 MARVIN FRA   SE OT        RE   A 100506      093006  090106



 Message
```

MAFI 11-06

- Enter Y in the confirm field

```
FINALIZE               MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 11 06                    0601   10 05 06
 AU ID XXXXXXXXX   Prog MA   Prog Type D        Med COA W01

 Resources                          Income Test Continued
   Resource Limit          2000.00   Allocated Income           .00
   Total Resources          475.00   Gross Unearned Income  1365.00
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   Pat Liability Income        .00   Net Unearned Income    1365.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income             1365.00
   IME Amount                  .00   Income Limit           1809.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
 Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons                 Recon Ind N
 Notice Type 0003           Waive Timely Ntc  Period     Notice Override
 Review Begin Date 10 06    Review End Date 10 07        Strat 1
 Message

  13-note
```

Scavenger Hunt Activity

Try to answer these questions based on what you have learned. If you need help, use the online help, valid values, or Desk Guide to answer the following questions:

1. On what two screens can you schedule an interview?

2. Which field on STAT is critical for budgeting?

3. Where do you go from DEM1 to change the Client Name?

4. What do you enter on ISM1?

5. Where do you enter information about an A/R's motor vehicle?

6. There are two screens for each client's job. What are they?

7. On UINC, what fields do you complete if the client has applied for SSI?

8. What does the Disposition Status field read when:
   - ❖ Application month has not been processed?
   - ❖ Application month has been processed but not finalized?
   - ❖ Application month has been finalized?

9. What key do you press on APP1 to complete the transaction and return to AMEN after you've processed all the application months?

10. What key do you press to save data to SPA?

JAMES COMPIANO
Medically Needy Initial Application, Prior months

Review Mr. Compiano's application on the next pages.

Your Assignment:

- Complete the policy questions related to this case
- Assume that you interviewed Mr. Compiano about his situation. During the interview, he provided his social security number—444-44-XXXX.
- During the interview, Mr. Compiano also stated he owns his home and his daughter, Janice, and her husband live with him. Their household expenses include:

  Mortgage $875/month
  Electricity $320/month
  Gas $136/month
  Cable TV $72/month
  Sewer and trash pickup $75/quarter
  Groceries $400/month

  Mr. Compiano states he pays $800/month to help with household expenses.

- Mr. Compiano states he would like to apply for Medicaid for July and August. He states he would like to have his bills paid for July and August rather than use the bills to meet ongoing spenddown.

- Prepare a verification checklist to send to Mr. Compiano.

- Complete the MN budget.

- Complete the Interview (O) process:

You will complete most of the screens independently. The social security number for Mr. Compiano was not available at the time of registration; the trainer will show you how to add this information using the CRS screen.

The ISM screen will need to be completed for Mr. Compiano since this is a Medically Needy case. Stop at ISM1 and wait for the trainer to walk through this screen with you.

Review the verification received, then process and finalize the case. After your case is finalized, wait for instruction regarding how to authorize the prior months.

Compare your MAFI screens to the ones in your Participant Guide.

Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries

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

INSTRUCTIONS:

1. Read the application carefully & answer each question accurately. Attach additional pages if needed.
2. **Sign and mail application to:** _____ County DFCS
   (Mail or deliver application to the DFCS office in your county of residence)

Application received 9/15/06
Registered AU ID XXXX00206

ATTN: _____

3. A telephone interview may be required for these programs. Be sure to enter phone # below.
4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

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

Applicant's Name (Last, First, Middle Initial) Compiano, James	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial) DAWKINS, Janice
Mailing Address	
Street Address 600 Dogwood Place	Mailing Address same
City Winder State GA Zip 30680	City State Zip
Do you own/are you purchasing home? ☑ Y ☐ N	
Phone 4046578875 County Barrow	Phone
E-Mail Address	E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual DAUGHTER

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self): James Compiano Maiden/other name(s):	Birthdate 12/9/39	Sex M	Race B	U.S. Citizen (Yes or No) Yes	Social Security Number ?	Marital Status W
Name (Spouse): Maiden/other name(s):						

Are you applying for your spouse, too? ☐ **Yes** ☑ **No**

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

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

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

DHR 700 (R. 11/08)

HEALTH INSURANCE:

Do you have Medicare?	Type of Coverage	Effective Date:	Have you ever received SSI?
☑ **Yes** ☐ **No** Are you enrolled in a Medicare HMO or Medicare Drug program? ☐ **Yes** ☑ **No**	☑ **Part A** (hospital) ☑ **Part B** (doctor) ☑ **Part D** (RX)	12/2004 Medicare Number: ?	☐ **Yes** ☑ **No** If so, when did it end?
Does your spouse have Medicare? ☐ **Yes** ☐ **No**	Type of Coverage ☐ **Part A** ☐ **Part B** ☐ **Part D**	Effective Date: Medicare Number:	Has your spouse ever received SSI? ☐ **Yes** ☐ **No** If so, when did it end?

Do you have other health insurance? ☐ **Yes** ☑ **No**

Does your spouse have other health insurance? ☐ **Yes** ☑ **No**

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.

REAL PROPERTY: Do you own all or part of any real estate in which you do not live? ☐ **Yes** ☑ **No**

If yes, please complete the following for each piece of real estate. **Do not list the house or mobile home in which you live.**

Address	Value	Amount Owed

Do you or your spouse own a car, truck, boat, camper, utility trailer, recreational vehicle, etc.?

☑ **Yes** ☐ **No** If yes, please complete the following information about each vehicle. Attach additional pages if needed.

Type	Year	Make	Model	Value	Amount Owed
Truck	03	Ford	F150	?	Ø

DHR 700 (R. 11/08)

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	☐ Yes	☑ No	Funeral plans/ prepaid burial item	☐ Yes	☑ No
Savings account	☐ Yes	☑ No	Burial plots or contracts	☐ Yes	☑ No
Government bonds	☐ Yes	☑ No	Stocks and bonds	☐ Yes	☑ No
Trust funds	☐ Yes	☑ No	Other (IRA, CD, promissory note, etc.)	☐ Yes	☑ No

Have you or your spouse given away any assets for less than its value? ☐ Yes ☑ No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

Do you or your spouse have a life insurance policy? ☐ Yes ☑ No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security	SSI	Wages/ Self-Employment
Railroad Retirement Benefits	Veterans' Benefits	Trust or Annuity Payments
Pensions/ Retirement Benefits	Rental Income Paid to You	Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
James	RSDI	Social Security	1061.50	Monthly	

Are you a veteran? ☐ Yes ☑ No Is your spouse a veteran? ☐ Yes ☑ No

Where did you and spouse work in the past? Self Employed

Do you or your spouse have any unpaid medical bills ? ☑ Yes ☐ No

DHR 700 (R. 11/08)

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 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: Janice Compiano	Date: 9/15/06
Signature of Applicant's Spouse or Representative: Janice Dawkins	Date: 9/15/06

DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the Unit States Department of Homeland Security (DHS) of my/my children's citizenship or alien 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	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)

(check whichever applies)

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

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth(city,state,country)	U.S. Citizen	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)
James Compiano	Austin, TX, US	✓		

(check whichever applies)

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

James Compiano
SIGNATURE (PARENT/GUARDIAN)

9/15/06
(DATE)

_____ SIGNATURE (PARENT/GUARDIAN)

_____ (DATE)

POLICY QUESTIONS

- **For what type of Medicaid is the AR applying (remember the CMD order of eligibility)?**

- **What is the SOP for this application?**

- **What type of interview is required?**

- **What mandatory forms must be completed?**

- **How will categorical relationship be verified for this AR?**

- **How will enumeration be verified?**

- **Does the AR need to apply for any other benefits?**

- **What are the AR's countable resources?**

- **How will each resource be verified?**

- **What is the AR's countable income?**

- **How will each type of income be verified?**

COMPLETE THE VERIFICATION CHECKLIST FOR THIS AR.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between _____AM and _____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

Living Arrangement/In-Kind Support and Maintenance Development Guide and Summary

A/R Name:

Part A – Living Arrangement (Enter "Yes" or "No". When "Yes", STOP – LA Established – Continue…)

1. Is Institutionalized? _____ **LA-D** (NH, Hospital, CCSP, Hospice, TEFRA Waiver, ICWP, MRWP)

   STOP: Do not develop ISM for any month the Medicaid CAP is used to determine eligibility.
   Case Manager should sign form above Part F on next page.

2. Is a Transient? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

3. Lives Alone? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

4. Lives Only with Spouse and/or Minor Children and/or Deemor? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

5. Owns own home? _____ **LA-A**

   If an adult other than A/R's spouse lives in HH – Develop Inside ISM – Complete Part B, **AND** Develop Outside ISM – Complete PartC, Part D, Part E and Part F.

6. Has rental liability? _____ **LA-A**

   If an adult other than A/R's spouse lives in HH – Develop Inside ISM – Complete Part BI, **AND** Develop Outside ISM – Complete Part C, Part D, Part E and Part F.

7. Lives in a PA Household? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

8. Lives with others and separately consumes and/or purchases food? _____ **LA-A**

   Develop Inside ISM for shelter only – complete Part B **AND** Develop Outside ISM – Complete Part C.
   Also complete Parts D, E and F.

9. Lives with others and meets sharing? _____ **LA-A**

_____	%	_____	=	_____	_____
Total HH Expenses		Number in HH		A/R's Pro Rata Share	A/R's Contribution

   Does the individual pay his pro rata share of household expenses? (Or within $5.00 of his share?)
   Develop Outside ISM – Complete Part C, Part D, Part Eand Part F. Do NOT develop Inside ISM if sharing exists.

10. Lives with others and meets earmarked sharing? _____ **LA-A**

_____	%	_____	=	_____	_____
Food Expenses Only		Number in HH		A/R's Pro Rata Share	A/R's Contribution

   NOTE: A/R must pay at least pro rata share – no $5.00 tolerance.

_____	%	_____	=	_____	_____
Shelter Expenses Only		Number in HH		A/R's Pro Rata Share	A/R's Contribution

   NOTE: A/R must pay at least pro rata share – no $5.00 tolerance.

   Does the individual earmark his contribution for food **OR** shelter? _____
   If "Yes", Develop Inside ISM for Food **OR** shelter – Complete Part B **AND**
   Develop Outside ISM – Complete Parts C, D and F.

11. Is subject to VTR? _____ **LA-B**

   A/R lives in the HH of another and is furnished food **AND** shelter by adult HH members other than spouse.
   Use FBR for LA-B. Do **NOT** develop ISM further – Complete Part E.

Part B – Inside ISM	**Individual/Individual with Ineligible Spouse**	**Couple**
Total HH Expenses **PAID** by HH Members	_____	
Divide by # of HH Members	÷ _____	
A/R's pro rata share	= _____	
Deduct A/R's Contribution	- _____	
Actual value of Inside ISM	= _____	

Part C – Outside ISM

Total HH Expenses PAID by non-HH members	_____
Divide by # of HH Members	÷ _____
Actual value of Outside ISM	= _____

Part D – Total ISM (Inside and Outside ISM)		**Cash to A/R with O.I. or R. L.**	
Inside ISM (Part II)	_____	Cash Contributions	_____
Outside ISM (Part III)	+ _____	HH Expense	- _____
Total ISM (Actual Value)	= _____	Cash Contribution	= _____
Chargeable ISM – Limited to PMV	_____	O.I. – Owenership Interest R.L. – Rental Liability	

Part E – Summary

_____ The one-third reduction does NOT apply because _____

LA –A. Chargeable ISM? $ _____. Cash Contribution? $ _____.

_____ The one-third reduction applies because _____

LA – B. Do NOT put any ISM in the Budget.

MES Signature _____ Date: _____

Part F – Household Expenses (To be completed by A/R or personal representative)

Work space for computing HH Expenses:

1. To determine if sharing or earmarked sharing exists, and
2. When developing **INSIDE** ISM

(Use only those amounts paid by the HH for **INSIDE ISM, SHARING, OR EARMARKED SHARING**. If not paid or paid by someone outside the HH, **USE ONLY FOR CONSIDERATION OF OUTSIDE ISM** .)

HH EXPENSES **The ONLY HH Expenses to be considered:**	**TOTAL HH MONTHLY EXPENSE AMOUNT**	**AMOUNT PAID BY PEOPLE WITHIN THE HOUSEHOLD**	**AMOUNT PAID BY PEOPLE OUTSIDE THE HOUSEHOLD**
Food (**DO NOT** count, if earmarked sharing for shelter)			
Mortgage (Including insurance required by mortgage holder)			
Rent (**DO NOT** count, if earmarked sharing for food)			
Real Estate Property Taxes			
Heating Fuel (Other than gas or electricity)			
Gas			
Electricity			
Water			
Sewer			
Garbage Removal			
TOTAL			

I verify that the above is a true representation of my household expenses and what I (and my spouse) pay toward these expenses.

Signature of Applicant/Recipient or Authorized Representative: _____ Date: _____

Signature of Person Paying Remainder: _____

Georgia Department of Human Resources

ABD Medicaid Individual/Couple/Spouse to Spouse Deeming Budget Sheet

AU Name:_____ AU # _____
Class of Assistance:_____ Living Arrangement: _____ Date:_____

Section A- Individual Calculation: Use to budget a Medicaid Individual OR a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) in LA-A or LA-B. Not for use on Medicaid Cap budgeting.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	
UNEARNED INCOME				
1. Enter A/R's Total GROSS Unearned Income				
2. Subtract $20 General Deduction. (Subtract $0 from IBON)				
3. Net Unearned Income (Line 1 minus Line 2)				
Earned Income (Go to Line 11 if no earned income)				
4. Enter A/R's Total GROSS Earned Income.				
5. Subtract remainder of $20 General Deduction.				
6. Subtotal (Line 4 minus Line 5)				
7. Subtract $65 Earned Income Deduction.				
8. Subtotal (Line 6 minus Line 7)				
9. Subtract ½ of Line 8.				
10. Subtotal (Line 8 minus Line 9)				AMN 3
TOTAL INCOME				Mo BP
11. Total Net Income (Line 3 plus Line 10)				
12. INDIVIDUAL Income Limit (FBR, Q-track, MNIL)				
13. Surplus/Deficit OR 1st Potential AMN Spenddown (Line 11 minus Line 12)				

NOTE: If a surplus exists on Line A.13, **STOP** (the A/R is ineligible) unless AMN. If a deficit exists or the COA is AMN continue.
NOTE: For Q Track eligibility, A/R must be eligible for the COA as an individual (Section A), in order to meet eligibility for the same COA as an individual with an ineligible spouse (Section C(. Example: A/R is SLMB eligible as an individual (Section A) but appears to be QMB eligible under Spouse to Spouse Deeming budget (Section C). A/R will only be eligible for SLMB, since s/he is ineligible for QMB as an individual.

Section B- Deeming From Ineligible Spouse: Use to budget a Medicaid Individual with an Ineligible Spouse (Spouse to Spouse Deeming) in LA-A or LA-B.	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____
UNEARNED INCOME			
1. Enter Ineligible Spouse's GROSS UNEARNED Income (Exclude IBON)			
2. Subtract Living Allowance for Ineligible Child(ren) minus the Child(ren)'s Income			
3. Ineligible Spouse(s)' UNEARNED Income to include in Section C (Line 1 minus Line 2)			
Earned Income			
4. Enter Ineligible Spouse(s)' GROSS EARNED Income.			
5. Subtract any portion of Living Allowance not subtracted from Unearned Income.			
6. Ineligible Spouse(s)' EARNED Income to include in Section C (Line 4 minus Line 5)			

Form 172 (R. 01/06)

ISM1

```
CHANGE                INKIND SUPPORT & MAINTENANCE 1 - ISM1          ISM1    A
  Month 11 06

 HOH Name JAMES          COMPIANO                   AU ID 175700206
 HH Expense Type     Amt     V           HH Expense Type      Amt    V
   Rent                                    Mortgage
   Electric                                Taxes
   Gas                                     Water
   Sewer                                   Garbage
   Heating Fuel                            Insurance
   Food                                    Other

   Clients Contrib           Outside Contrib          Inside Contrib
 Type        Amt     V    Type        Amt     V    Type        Amt     V
 Food                     Food                     Food
 Shelter                  Shelter                  Shelter
 Other                                             Other

 Number    Sharing   Household     Ownership    Parent/
 Food      Shelter   Situation     Rent Lib     Child
  01         01         AL             Y
 Message

                 15-lett
```

```
UPDATE                REMARKS - REMA & MAINTENANCE 1 - ISM1          REMA

********************************** ISM1 ****************************************
9/15/06 10:14 AM IMA WORKER, 875H, 105, ANY, 478-567-4353
Brief summation of household situation – who is in the home and what is their
relationship to a/r?:_A'R DAUGHTER & HER HUSBAND LIVES IN HOME_____________
:_____________________________________________________________________________
:_____________________________________________________________________________
Brief summation of how household expenses are shared:_________________________
:_ALL HOUSEHOLD EXPENSES ARE SHARED BETWEEN A/R, DAUGHTER, SON-IN-LAW__________



 Message

                 15-lett
```

ELIG 11/06

NOTE THE AU STAT IS "M", IN SUSPENSE WAITING TO MEET SPENDDOWN

```
CHANGE             NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
  Month 11 06                     7591   10 05 06                      01

 AU ID 175700206    Prog MA    Prog Type A    Med COA S99
 Confirm

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  M    347           100506   091506
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 JAMES  COM   SE OT        RE   A 100506 347  091506


 Message
```

MAFI 11/06

NOTE THE SPENDDOWN AMOUNT

```
CHANGE                 MA FINANCIAL ELIGIBILITY - MAFI              MAFI    A
  Month 11 06                    7591   10 05 06
 AU ID 175700206   Prog MA   Prog Type A        Med COA S99

 Resources                          Income Test Continued
   Resource Limit          2000.00   Allocated Income           .00
   Total Resources             .00   Gross Unearned Income  1150.00
 Patient Liability/Cost Share        General Inc Deduction    20.00
   Pat Liability Income        .00   Net Unearned Income    1130.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income             1130.00
   IME Amount                  .00   Income Limit            317.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount        813.00
 Income Test                         Medical Expense Amt        .00
   Gross Deemor Income         .00   Net Spenddown Amount    813.00

 Bnft Eff Date         Bnft Confirm     Reasons 347            Recon Ind
 Notice Type                Waive Timely Ntc  Period     Notice Override
 Review Begin Date 09 06    Review End Date 02 07        Strat 2
 Message

  13-note
```

ISM 2 11/06

FOR MN CASES, ISM2 WILL DISPLAY DURING PROCESSING AND FINALIZATION

```
CHANGE                INKIND SUPPORT & MAINTENANCE 2 - ISM2          ISM2    A
  Month 11 06                     7591   10 05 06

 AU ID 175700206    Prog MA      Prog Type A       Med COA S99



                   Cash Contribution Amount         .00

                   Inside   ISM Amount              .00

                   Outside  ISM Amount              .00

                   Total    ISM Amount              .00
```

DONE 11/06

AT DONE, ABD MEDICALLY NEEDY CASES IN SUSPENSE INQUIRE ABOUT MEETING SPENDDOWN, F4 AROUND THIS MESSAGE

```
CHANGE                        SESSION SUMMARY - DONE                    DONE
  Month 11 06                                                              01




   AU ID   Prog  Med COA    Elig   - Status -    - Benefit --   Outstanding
                            Req    Code Cfirm    Amt   Cfirm  Verifications
 175700206 MA      S99       N      M




 Message 1351
 1351 DOES THIS AU NEED "SPENDDOWN AUTHORIZATION"?
                                        16-prwp  20-edd  21-narr
```

SDME 07/06 “Z” PROCESS (INQUIRY)

```
INQUIRY                SPENDDOWN MEDICAL EXPENSES - SDME            SDME 01
Month 07 06                       7571   10 05 06                     01  MORE

 HOH Name    JAMES        COMPIANO                Client ID 557000323
 AU ID 155700206

 Del  Expense    Amt   V        Date          TPL     A/R   Exp Pd   SD
      Covered                 Incurred        Amt     Bill  Rollover Use
       Y     88.50     OT     07 01 06                 Y       U      U
      Provider Name SOCIAL SECURITY OFFICE      Exp Typ N    CL ID 557000323
       Y     176.40    BI     07 03 06                 Y       P      U
      Provider Name KROGER PHARMACY             Exp Typ P    CL ID 557000323
       Y     180.00    BI     07 19 06                 Y       P      U
      Provider Name KROGER PHARMACY             Exp Typ P    CL ID 557000323
       Y     1828.40   BI     07 19 06                 Y       U      B
      Provider Name EMORY CLINIC                Exp Typ N    CL ID 557000323
       Y     131.00    BI     07 24 06                 Y       U      N
      Provider Name EMORY CLINIC                Exp Typ N    CL ID 557000323

                             Client Liability Amt for Breakeven Bill     368.10
                                                                More Med Exp
 Message
                 15-lett                                                24-deL
```

SDME 07/06 “Z” PROCESS (INQUIRY) (CONTINUED)

```
INQUIRY                SPENDDOWN MEDICAL EXPENSES - SDME             SDME 01
Month 07 06                      9371  10 05 06                        02

 HOH Name    JAMES        COMPIANO                 Client ID 539000323
 AU ID 153900206

 Del  Expense    Amt   V        Date          TPL     A/R   Exp Pd   SD
      Covered                 Incurred        Amt     Bill  Rollover Use
       Y     150.00    RC     07 24 06                 Y       P      N
      Provider Name KROGER PHARMACY             Exp Typ P    CL ID 539000323

      Provider Name                             Exp Typ      CL ID

      Provider Name                             Exp Typ      CL ID

      Provider Name                             Exp Typ      CL ID

      Provider Name                             Exp Typ      CL ID

                             Client Liability Amt for Breakeven Bill
                                                                More Med Exp
 Message

                 15-lett                                              24-deL
```

SDME FOR 8/06 “Z” PROCESS (INQUIRY)

```
INQUIRY                SPENDDOWN MEDICAL EXPENSES - SDME             SDME 01
Month 08 06                      9371   10 05 06                        01 MORE

 HOH Name    JAMES        COMPIANO                 Client ID 539000323
 AU ID 153900206

 Del  Expense    Amt   V        Date          TPL     A/R   Exp Pd   SD
      Covered                 Incurred        Amt     Bill  Rollover Use
       Y     88.50     OT     08 01 06                       U       U
      Provider Name SOCIAL SECURITY ADMIN       Exp Typ N    CL ID 539000323
       Y     179.50    RC     08 03 06                Y      P       U
      Provider Name Kroger Pharmacy             Exp Typ P    CL ID 539000323
       Y     296.30    RC     08 10 06                Y      P       U
      Provider Name Kroger Pharmacy             Exp Typ P    CL ID 539000323
       Y     304.00    BI     08 19 06                Y      U       B
      Provider Name Orthopedic SURG/SPTS MED    Exp Typ N    CL ID  539000323
       Y     589.00    BI      08 20 06               Y      U       N
      Provider Name GWINNETT HOSPITAL SYSTEM    Exp Typ N    CL ID  539000323

                             Client Liability Amt for Breakeven Bill 248.70
                                                                More Med Exp
 Message

                 15-lett                                              24-deL
```

SDME FOR 8/06 “Z” PROCESS (INQUIRY) (CONTINUED)

```
INQUIRY                SPENDDOWN MEDICAL EXPENSES - SDME             SDME 01
Month 08 06                       9371    10 05 06                      02

 HOH Name    JAMES        COMPIANO                 Client ID 539000323
 AU ID 153900206

 Del  Expense    Amt   V        Date          TPL     A/R   Exp Pd   SD
      Covered                 Incurred        Amt     Bill  Rollover Use
       Y         71.00 BI     08 24 06                  Y      U      N
      Provider Name ORTHOPEDIC SURG/SPTS MED    Exp Typ N    CL ID 539000323
       Y        125.00 RC     08 24 06                  Y      P      N
      Provider Name Kroger Pharmacy             Exp Typ P    CL ID 539000323
       Y        184.30 BI     08 24 06                  Y      U      N
      Provider Name GWINNETT HOSPITAL           Exp Typ N    CL ID 539000323

      Provider Name                             Exp Typ      CL ID

      Provider Name                             Exp Typ      CL ID

                              Client Liability Amt for Breakeven Bill
                                                                 More Med Exp
 Message

                 15-lett                                                24-deL
```

SUCCESS Participant Guide

Casework Skills

OUTLINE FOR CASEWORK SKILLS

I. INTRODUCTION

II. EXPECTATIONS OF THE JOB

III. COMPONENTS OF A GOOD HELPING RELATIONSHIP

IV. STAGES OF THE INTERVIEW

V. PREPARING FOR THE INTERVIEW

VI. BEGINNING THE INTERVIEW

VII. THE WORK STAGE

VIII. ENDING THE INTERVIEW

IX. REAL PLAYS, HERBERT BLACK AND MARION SMITH

OBJECTIVES FOR CASEWORK SKILLS

- ✓ Participants will discuss the components of a good helping relationship.
- ✓ Participants will be able to identify the four stages of an interview.
- ✓ Participants will be able to prepare for the interview.
- ✓ Participants will be able to discuss appropriate greetings to begin an interview.
- ✓ Participants will be able to develop open questions to get an overview of the applicant/ recipient's situation.
- ✓ Participants will be able to discuss the work stage of the interview.
- ✓ Participants will discuss attending skills used during the interview.
- ✓ Participants will discuss techniques used to gather and give information.
- ✓ Participants will be able to discuss summarization of the interview.
- ✓ Participants will be able to discuss appropriate ways to end the interview.

Components of a Good Helping Relationship

In order to establish a good helping relationship with your client, consider and act upon the following components:

- ✓ **Respect for a client's individuality** – Respond to the client as a unique individual rather than stereotyping. Treat the client as you would want to be treated.

- ✓ **Non-judgmental attitudes** – Accept the client by behaving in a manner in which respect and concern is demonstrated even though you may reject some of the client's behaviors.

- ✓ **Trust** – Operate on the premise that a person is honest until proven to be dishonest.

- ✓ **Genuineness and Interest** – Show concern and interest in the client's needs by listening to the client's story and responding with empathy.

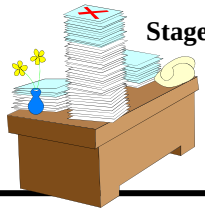
- ✓ **Empathic Understanding** – Feel with the client rather than for the client (sympathy).

- ✓ **Acknowledge client's self-determination** – Establish an atmosphere that encourages client's participation and respects the client's initiative. Acknowledge the client's right and capacity to direct their own lives.

- ✓ **Consistency and reliability** – Advise the client of what to expect from you. Make sure the client understands what you can and cannot do.

- ✓ **Confidentiality** - Respect the client's right to confidentiality. Assure the client that the information shared in the interview will not be made available to the public or other agencies.

Stages of the Interview



Stage 1

Preparing for the Interview

Beginning the Interview

Stage 2

Stage 3

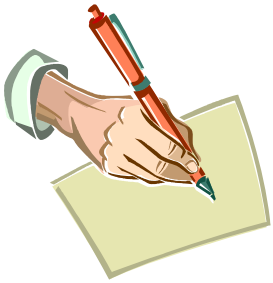
The Work Stage

Ending the Interview

Stage 4

Stages of the Interview

Notes Page



Stage 1 - Preparing for the Interview

Stage 2 – Beginning the Interview

Stage 3 – The Work Stage

Stage 4 – Ending the Interview

The Work Stage

Attending Skills to Use During the Interview
Identify the following as Negative (N) or Positive (P) attending skills.

Eye Contact ___ a. Frequently loses eye contact ___ b. Stares at client ___ c. Looks at client when talking ___ d. Avoids eye contact	**Voice** ___ a. Speaks too slowly or too quickly ___ b. Speaks too loudly or too softly ___ c. Little change in inflection ___ d. Variation in tone; appropriate speech rate and loudness
Posture ___ a. Face and/or body turned away from client ___ b. Body faces client, slight lean ___ c. Tense; slouched; arms and legs crossed ___ d. Leans away from the client; aggressively leans forward	**Verbal Following** ___ a. Stays on topic ___ b. Switches topic ___ c. Interrupts client ___ d. Makes a smooth transition from one topic to another topic
Facial Expressions ___ a. Facial expressions tense, blank, or distracting ___ b. Calm yet expressive facial expressions ___ c. Facial expressions congruent with client's expression	**Congruence** ___ a. Discrepancy between client and worker in verbal and nonverbal communication ___ b. Verbal and nonverbal communication congruent with the client's communication
Gestures ___ a. Uses gestures for emphasis ___ b. Occasional head nods ___ c. Excessive use of head nods ___ d. Spontaneous and fluid use of hands and arms ___ e. Inappropriate gestures. e.g., rigid or fidgeting movements, preoccupation with pencil, etc	**Minimal Encouragers** ___ a. Repeats one or two key words ___ b. "Um-hum" ___ c. One-word questions (e.g., "Oh?", "Really?") ___ d. Head nods ___ e. "Tell me more" ___ f. Excessive head nods or excessive "um-hums"

ASK OPEN QUESTIONS

For each of the topics listed below, create at least two open questions to use during the interview.

RESOURCES

_____

_____

INCOME

_____

_____

MEDICAL BILLS

_____

_____

POSSIBLE ISM

_____

_____

SUCCESS Participant Guide

Reviews

Objectives

Participants will be able to:

√ complete a review on an existing case

√ process a spenddown month on an ongoing case

Outline

I. Introduction

II. Reviews Timeline

III. John Dunne – Walk Through Review

IV. Albert Baker – Independent Study Review

V. Review

Reviews

SUCCESS schedules review appointments in the last 5 working days of the month prior to the month in which the reviews are due and up until the 15th of the month in which the reviews are due. For example, reviews in which the Period of Eligibility ends on May 31, 2007 will be scheduled from April 27, 2007 through May 15, 2007. Leave enough slots available during these days for SUCCESS to schedule your reviews.

Sample Schedule

The following is a daily schedule for a case manager with core work hours of 8:00 am – 5:00 pm who takes lunch from 12:00 – 1:00. This case manager also has a doctor's appointment scheduled for 8:00 am, so one hour of sick leave from 8:00 until 9:00 has been scheduled.

UPDATE DAILY SCHEDULE – SCHD
SCHD

FRIDAY **Load**

ID 900A

S	**Time**	**CL/AU**	**Appt**	**L. Name / Remarks**	**Date**
05 22 07					
B	7:00		PT	Work Hours 8:00 – 5:00	
	7:30		C		
	8:00		SL	Drs. Appointment	
	8:30		C		
	9:00				
	9:30				
	10:00				
	10:30				
	11:00				
	11:30				
	12:00		LUN		
	12:30		C		
	1:00				
	1:30				
	2:00				
	2:30				

3:00
3:30
Message
13-day+ 14-day-

UPDATE **DAILY SCHEDULE – SCHD**
SCHD

FRIDAY **Load**

ID 900A

S	**Time**	**CL/AU**	**Appt**	**L. Name / Remarks**	**Date**
05 22 07					
	4:00				
	4:30				
B	5:00		PT		
	5:30		C		
	6:00		C		
	6:30		C		

The PT code indicates that the case manager is on Personal Time. The C code continues the Appointment Type to the next time slot. The B code in the S field indicates that the case manager has selected to block the corresponding time slot. These time slots will be carried over from the day it is set until the end of the case manager's calendar for the next eight weeks. To override the block, go to the specific day that needs to be changed and make any necessary changes.

Step into the Review on SUCCESS

Step 5
If verification is required, enter verification code OT so that SUCCESS will pend the case until the actual verification is received.

Step 4
Review documentation. Document any AU changes. Correct prior mistakes. Re-verify per policy and **re-key ALL verification in yellow.**

Step 3
From AMEN select **R** to complete the review. Enter the client ID number. Review ALL points of eligibility.

Step 2
From AMEN select **N** to initiate the review using the client ID number, then on the **REDE** screen, enter the Recert App Date, then type **Y** in Recert Sel for each AU due for review.

Step 1
From AMEN, select **B** then enter the AU ID number. Press PF11 to get the client ID number for the Head of Household.

FOR COUNTY USE ONLY: Date Received in County Dept	Georgia Department of Human Resources **MEDICAID REVIEW FORM**	**DATE DUE:**

AU#:		Load#
Client's Name	Birthdate:	SSN:
Address		

It is time for your Medicaid Review. Please complete the form and return or your Medicaid will stop.

1. Have you moved? ☐ No ☐ Yes
   If yes, give us your new address: _____

2. Please list all persons living with you. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid.

First Name	MI	Last Name	Date of Birth	Sex M/F	Is Medicaid requested for this individual? (Y/N)	Relationship to you	Social Security Number	Is this person a U.S. Citizen? (Y/N)

3. Is anyone pregnant? ☐ Yes ☐ No If Yes, Who? _____
4. Does the father of your child(ren) live in your household? ☐ Yes ☐ No
5. Does anyone in the household have any unpaid medical bills? ☐ Yes ☐ No If yes, please send current bills.
6. Do you have other Health Insurance? ☐ Yes ☐ No If yes, send us a copy of your insurance card.
7. **Resources:** Check all resources (assets) owned by you, your spouse, your dependents, or any resources jointly owned with someone else. Attach additional pages if necessary.

Cash	☐Yes	☐No	Certificates of Deposit	☐Yes	☐No
Checking Accounts	☐Yes	☐No	Funeral Plans/Prepaid Burial	☐Yes	☐No
Savings Accounts	☐Yes	☐No	Burial Plots or Contracts	☐Yes	☐No
Credit Union Accounts	☐Yes	☐No	Stocks and Bonds	☐Yes	☐No
Annuities	☐Yes	☐No	Trust Funds	☐Yes	☐No
Government Bonds	☐Yes	☐No	Non-Home Place Property	☐Yes	☐No
Safety Deposit Box	☐Yes	☐No	Tax Refund	☐Yes	☐No
Retirement Accounts	☐Yes	☐No	Home Place Property	☐Yes	☐No
Vehicles	☐Yes	☐No	Life Insurance	☐Yes	☐No
			Other Resources	☐Yes	☐No

If you answered yes to any of these questions, please describe below and provide proof.

Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.

Form 222 (Rev 11/08)

8. **Income and Earnings:** Check all income owned by you, your spouse, and your dependents, or any income jointly received with someone else.

Wages or Salaries	❑Yes	❑No	Tips or Commission	❑Yes	❑No
Disability or sick pay	❑Yes	❑No	Self-employment or Odd jobs	❑Yes	❑No
Unemployment Benefits	❑Yes	❑No	Severance Pay	❑Yes	❑No
Social Security Income	❑Yes	❑No	Interest or Dividends	❑Yes	❑No
Worker's Compensation	❑Yes	❑No	Veteran's Benefits	❑Yes	❑No
Pension or Retirement	❑Yes	❑No	Rental Property Income	❑Yes	❑No
Child support or Alimony	❑Yes	❑No	Military Allotments	❑Yes	❑No
Adoption Assistance	❑Yes	❑No	Foster/Relative Care Pay	❑Yes	❑No
Contributions from others	❑Yes	❑No	Other income (specify)	❑Yes	❑No

If you answered yes to any of these questions, please provide proof.
Complete the information below for every person with income:

Person with income	Source of Income	How often income received	Amount

9. Does anyone pay child or dependent care cost? ☐ Yes ☐ No
Child's name: _____ Amount Paid: _____ How often paid: _____

10. Have you transferred or given away any assets or property in the past 60 months? ☐ Yes ☐ No
If yes, explain: _____

IMPORTANT: If your benefits change as a result of this review, we will send you a notice explaining what will happen. If you do not agree with our decision, you can request a fair hearing.

- I understand that if I am not satisfied with the action taken on my case, I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the county office where I applied.
- I understand that any lump sum or "windfall" payment that any person in my Medicaid case receives must be budgeted, along with any other income that we might have, to determine eligibility.
- I agree to provide the county and/or representative of the Department of Human Resources information necessary for verifying any statement given on this form and hereby give permission to the same to obtain verification of such information if needed.
- 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 such as banks, saving and loan associations, credit reporting bureaus, and other county, state, and federal government agencies, including Internal Revenue Service, to verify eligibility for assistance.
- **Assignment of Rights of Payment for Medical Support and other Medical Care:** 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. (If you are completing this form 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 above as a condition of his/her eligibility for Medicaid.)

PENALTY WARNING

I understand that: If I give false information or withhold information, I may be prosecuted for fraud.
I must also report all changes in my situation within 10 days of becoming aware of a change.

TO THE BEST OF MY KNOWLEDGE, I SWEAR OR AFFIRM THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT.

SIGN, DATE AND RETURN THIS FORM BY THE DUE DATE ON THE FRONT OF THE FORM

YOUR SIGNATURE OR MARK: _____ _____
Date

PHONE NUMBER: _____ **E-MAIL ADDRESS:** _____

SIGNATURE OF PERSON HELPING TO COMPLETE THIS FORM: _____ **DATE:** _____

DO YOU WANT THIS PERSON AS YOUR PERSONAL REPRESENTATIVE? ☐ Yes ☐ No

JOHN DUNNE
Process a Review

Background: Mr. John Dunne was approved for QMB Medicaid in September 2005. He has completed his Form 222 and mailed it in to his local DFCS office. The MES receives the review form on 9/24/06.

Your Assignment: Initiate and complete the review using Mr. Dunne's Form 222 to update the information in his case. The trainers will assist you as needed.

FOR COUNTY USE ONLY: Date Received in County Dept 9/24/06	Georgia Department of Human Resources **MEDICAID REVIEW FORM**	**DATE DUE: 10/15/06**

AU#: XXXX00019 Load# XXXX
Client's Name John Dunne Birthdate: 01-09-29 SSN: 02401XXXX
Address 7804 Marietta St., Atlanta, Ga. 30301

It is time for your Medicaid Review. Please complete the form and return or your Medicaid will stop.

1. Have you moved? ☑ No ☐ Yes
   If yes, give us your new address: _____

2. Please list all persons living with you. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid.

First Name	MI	Last Name	Date of Birth	Sex M/F	Is Medicaid requested for this individual? (Y/N)	Relationship to you	Social Security Number	Is this person a U.S. Citizen? (Y/N)

3. Is anyone pregnant? ☐ Yes ☑ No If Yes, Who? _____
4. Does the father of your child(ren) live in your household? ☐ Yes ☐ No
5. Does anyone in the household have any unpaid medical bills? ☐ Yes ☑ No If yes, please send current bills.
6. Do you have other Health Insurance? ☐ Yes ☑ No If yes, send us a copy of your insurance card.
7. **Resources:** Check all resources (assets) owned by you, your spouse, your dependents, or any resources jointly owned with someone else. Attach additional pages if necessary.

Cash	☐Yes	☑No	Certificates of Deposit	☐Yes	☑No
Checking Accounts	☑Yes	☐No	Funeral Plans/Prepaid Burial	☐Yes	☑No
Savings Accounts	☐Yes	☑No	Burial Plots or Contracts	☐Yes	☑No
Credit Union Accounts	☐Yes	☑No	Stocks and Bonds	☐Yes	☑No
Annuities	☐Yes	☑No	Trust Funds	☐Yes	☑No
Government Bonds	☐Yes	☑No	Non-Home Place Property	☐Yes	☑No
Safety Deposit Box	☐Yes	☑No	Tax Refund	☐Yes	☑No
Retirement Accounts	☐Yes	☑No	Home Place Property	☐Yes	☑No
Vehicles	☐Yes	☑No	Life Insurance	☑Yes	☐No
			Other Resources	☐Yes	☑No

If you answered yes to any of these questions, please describe below and provide proof.

Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.
Checking Account		800	Wachovia Bank
Term Life Ins	5732	10,000	General American

Form 222 (Rev 11/08)

8. **Income and Earnings:** Check all income owned by you, your spouse, and your dependents, or any income jointly received with someone else.

Wages or Salaries	☐Yes	☑No	Tips or Commission	☐Yes	☑No
Disability or sick pay	☐Yes	☑No	Self-employment or Odd jobs	☐Yes	☑No
Unemployment Benefits	☐Yes	☑No	Severance Pay	☐Yes	☑No
Social Security Income	☑Yes	☐No	Interest or Dividends	☐Yes	☑No
Worker's Compensation	☐Yes	☑No	Veteran's Benefits	☐Yes	☑No
Pension or Retirement	☑Yes	☐No	Rental Property Income	☐Yes	☑No
Child support or Alimony	☐Yes	☑No	Military Allotments	☐Yes	☑No
Adoption Assistance	☐Yes	☑No	Foster/Relative Care Pay	☐Yes	☑No
Contributions from others	☐Yes	☑No	Other income (specify)	☐Yes	☑No

If you answered yes to any of these questions, please provide proof.
Complete the information below for every person with income:

Person with income	Source of Income	How often income received	Amount
John Dunne	Social Security	Monthly	600
John Dunne	Retirement	monthly	200

9. Does anyone pay child or dependent care cost? ☐ Yes ☑ No
Child's name: _____ Amount Paid: _____ How often paid: _____

10. Have you transferred or given away any assets or property in the past 60 months? ☐ Yes ☑ No
If yes, explain: _____

IMPORTANT: If your benefits change as a result of this review, we will send you a notice explaining what will happen. If you do not agree with our decision, you can request a fair hearing.

- I understand that if I am not satisfied with the action taken on my case, I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the county office where I applied.
- I understand that any lump sum or "windfall" payment that any person in my Medicaid case receives must be budgeted, along with any other income that we might have, to determine eligibility.
- I agree to provide the county and/or representative of the Department of Human Resources information necessary for verifying any statement given on this form and hereby give permission to the same to obtain verification of such information if needed.
- 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 such as banks, saving and loan associations, credit reporting bureaus, and other county, state, and federal government agencies, including Internal Revenue Service, to verify eligibility for assistance.
- **Assignment of Rights of Payment for Medical Support and other Medical Care:** 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. (If you are completing this form 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 above as a condition of his/her eligibility for Medicaid.)

PENALTY WARNING

I understand that: If I give false information or withhold information, I may be prosecuted for fraud.
I must also report all changes in my situation within 10 days of becoming aware of a change.

TO THE BEST OF MY KNOWLEDGE, I SWEAR OR AFFIRM THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT.

SIGN, DATE AND RETURN THIS FORM BY THE DUE DATE ON THE FRONT OF THE FORM

YOUR SIGNATURE OR MARK: John Dunne _____ 9/24/06 **Date**

PHONE NUMBER: _____ **E-MAIL ADDRESS:** _____

SIGNATURE OF PERSON HELPING TO COMPLETE THIS FORM: _____ **DATE:** _____

DO YOU WANT THIS PERSON AS YOUR PERSONAL REPRESENTATIVE? ☐ Yes ☐ No

STEP ONE: LOCATE CLIENT ID NUMBER

AMEN

- Select B
- Enter Mr. Dunne's AU ID number
- Press PF11 to get client ID number
- PF3 to exit

STEP TWO: INITIATE REVIEW

AMEN

- Select **N** and enter Mr. Dunne's client ID number
- Press Enter

REDE:

- Enter 09/24/06 in Recert Appl Date field
- Enter Y in the Sel field
- Press ENTER

```
UPDATE                    INITIATE REVIEW - REDE                    REDE
 Month 11 06                                                          01

 Recert Appl Date  09 24 06  Delay Rsn
 Sel     F Name    MI      L Name            AU ID      Prog   Review Process
                                                                Begin Date

  y      JOHN             DUNNE             XXXXXXXXX   MA




 Message
```

STEP THREE: START THE INTERVIEW/COMPLETE UPDATES

AMEN:

- Select R
- Press ENTER

Update the information in Mr. Dunne's case using his Form 222. Document on the NARR screen. Remember to update verification codes highlighted in yellow. Stop at the MISC screen and wait for the trainers to walk you through the new information

```
CHANGE                    CLIENT DEMOGRAPHIC 2 - DEM2                          DEM2 01
 Month 11 06                     8991   10 01 05

 Client Name JOHN           DUNNE                 Client ID 785000018

 Citiz V  Student V  High Grade V Striker ---Immunization -  Law -Health Chk -
          Stat       Completed    Stat      Curr GCse Due Dt  Brkr Ref   Date
   C   OT                            N

TPL  TPL   V  ------ Medicare -----    ------  Disability / Incapacity ------
     Coop     Entitlmnt   Claim Num    Disab  Approval Begin Date        End Date
                                       Type   Source  (MM YYYY)         (MM YYYY)
  N   C    CS    Y        024011137A

Joint  Vet   Military    Death   TANF Cap Parent ------ TANF Cap Child ----
SSI/FS Stat  Serv Num    Date     Ctr  End Date  Parnt ID Rcv Mo Cncpt GCse
        N

 Non-Custodial Parent?     V


 Message 0794
 0794 VERIFICATION NEED TO BE UPDATED DURING THE R/R PROCESS
               15-lett                                    22-tpl 23-alau
```

```
CHANGE                        RESOURCES 1 - RES1                     RES1 01
 Month 11 06                     8991   07 01 06                       01

 Client Name JOHN           DUNNE                 Client ID 785000018

 Do you have any of the following: cash, money loaned out, checking, savings,
 credit union, CD's, stocks, bonds, or secured notes?

 Del Type   Amount   V       Acct Num        Institution Name
      CH      200  CS                         Wachovia


 Do you have any of the following: life insurance, pre-paid burial contracts,
 real estate, or cemetery lots?

 Del Type Face Amt   Cash Amt V    Policy Num        Company Name
     BC   10000.00   ?        CS   5732              GENERAL AMERICAN
                                                                          MORE
 Message  0779 01     0794 01
0779 SHOULD THIS AMOUNT BE ZERO?
                 15-lett                                      23-alau   24-del
```

```
CHANGE                      UNEARNED INCOME - UINC                  UINC 01
 Month 11 06                            10 01 05                     01 MORE

 Client Name JOHN           DUNNE                 Client ID 785000018

Do you have any of the following: RSDI, alimony, direct child support,
contributions, VA, workers compensation, unemployment, sick/disability benfits,
pension, railroad retirement, any other retirement, rent, interest, annuities,
dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay
 RB            MO

 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V
 09 01 06     200.00  CS


                                     Client Potentially Elig For Other Benefits?
                                                                        More
 Appl Type     Stat    Date                 Appl Type     Stat    Date
 Message 1968      1965      1970
 1968 NO SDX DATA AVAILABLE
          15-lett                        16-uvnc           23-alau  24-del
```

```
CHANGE                      UNEARNED INCOME - UINC                  UINC 01
 Month 11 06                     8991   10 01 05                     02

 Client Name JOHN           DUNNE                 Client ID 785000018

Do you have any of the following: RSDI, alimony, direct child support,
contributions, VA, workers compensation, unemployment, sick/disability benfits,
pension, railroad retirement, any other retirement, rent, interest, annuities,
dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay
 SA            MO     024011137A

 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V
 09 01 06    600.00   BX


                                   Client Potentially Elig For Other Benefits?
                                                                        More
 Appl Type     Stat    Date                 Appl Type     Stat    Date
 Message 0794
 0794 VERIFICATIONS NEED TO BE UPDATED DURING THE R/R PROCESS
          15-lett                        16-uvnc           23-alau  24-del
```

MISC:

- Enter Y in the Review Completed field
- Enter A in the Next Review field
- Press ENTER

```
CHANGE              AU NON-FINANCIAL MISCELLANEOUS - MISC            MISC    A
  Month 11 06                     A137   11 15 05

 HOH Name JOHN          DUNNE                 Client ID XXXXXXXXX
 AU ID XXXXXXXXX    Prog MA

 Pre    Pre   AU  ATP  ATP  QRF  QRF Pre- Calc Trial Pro Exp SLAM -Extended MA-
 Issn   EBT  Issn Prnt Cyc Status Ctr sump Elig  HH   Ovr Svc Cd  Start Dt  COA
        Card Mode Cnty Num  Code      Elig Ind   Ind                        Cor


 ----- Review ----   Auto   ------- Lump Sum Remainder ------  Delay  QMB   RSM
 Compl  Mand  Last  Reasgn  Amount    100 %    133 %    185 %   Rsn   Ovr  Elig
        Std   Type   Ovr                                                    Ovr
   Y           A      N
 Sched Interview          QC Penalty End Date
 Del      Unit Number 120102     Inquiry Date 11 15 05       Load ID
      Next Review A                 Appt Date               Appt Type
      Appt Begin Time (HH:MM)    :
      Appt End Time (HH:MM)      :           Appt Letter Print Location L
      L Name/Appt Remarks
 Message 1455
 1455 DID YOU MEAN TO LEAVE REDETERMINATION INCOMPLETE ON 'MISC'?
 13-note 14-schd 15-lett                        20-schs       23-alau
```

```
CHANGE             NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
Month 11 06                     8991   10 01 05                      01

AU ID 000000019    Prog MA    Prog Type A    Med COA Q01
Confirm  Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
Stat    Reasons      Date     Date     Date     Date    Type  End Date
  A                  100105   093005   110105
-------------------------------------------------------------------------------
First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
JOHN   DUN   SE BC        RE   A 100105     093005 110105

Message
```

```
CHANGE                 MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
Month 11 06                     8991   10 05 06
AU ID 000000019   Prog MA   Prog Type A        Med COA Q01

Resources                          Income Test Continued
   Resource Limit          4000.00   Allocated Income           .00
   Total Resources             .00   Gross Unearned Income   800.00
Patient Liability/Cost Share        General Inc Deduction    20.00
   Pat Liability Income        .00   Net Unearned Income     780.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income              780.00
   IME Amount                  .00   Income Limit            817.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount
Income Test                         Medical Expense Amt
   Gross Deemor Income         .00   Net Spenddown Amount

Bnft Eff Date 100105 Bnft Confirm y   Reasons                 Recon Ind
Notice Type                Waive Timely Ntc  Period     Notice Override
Review Begin Date 11 06    Review End Date 10 07        Strat
Message

  13-note
```

ALBERT BAKER
Process a Review

Background: Mr. Albert Baker was approved for MN Medicaid in September 2005. He has completed his Form 222 and mailed it in to his local DFCS office. The MES receives the review form and two medical bills for July on 9/24/06. Medicare payments were made on all bills attached. MES spoke with Mr. Baker on the phone and he states he wants us to pay the 7/06 bills rather than use them to meet ongoing spenddown. Mr. Baker also states that no one helps him with his household bills.

Your Assignment: Initiate and complete the review using Mr. Baker's Form 222 to update the information in his case. The trainers will assist you as needed.

Mr. Baker is an "independent study" case. The trainer will not go through the screens with you, but will be available to answer questions. Please work independently on this case.

FOR COUNTY USE ONLY: Date Received in County Dept 9/24/06	Georgia Department of Human Resources **MEDICAID REVIEW FORM**	**DATE DUE:** 10/15/06

AU#: XXXX00040 Load# XXXX
Client's Name Albert Baker Birthdate: 12/09/41 SSN: 52201XXXX
Address 122 Bartlett Drive, Atlanta, Ga. 30301

It is time for your Medicaid Review. Please complete the form and return or your Medicaid will stop.

1. Have you moved? ☑ No ☐ Yes
   If yes, give us your new address: _____

2. Please list all persons living with you. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid.

First Name	MI	Last Name	Date of Birth	Sex M/F	Is Medicaid requested for this individual? (Y/N)	Relationship to you	Social Security Number	Is this person a U.S. Citizen? (Y/N)

3. Is anyone pregnant? ☐ Yes ☑ No If Yes, Who? _____
4. Does the father of your child(ren) live in your household? ☐ Yes ☐ No
5. Does anyone in the household have any unpaid medical bills? ☑ Yes ☐ No If yes, please send current bills.
6. Do you have other Health Insurance? ☐ Yes ☑ No If yes, send us a copy of your insurance card.
7. **Resources:** Check all resources (assets) owned by you, your spouse, your dependents, or any resources jointly owned with someone else. Attach additional pages if necessary.

Cash	☐Yes	☑No	Certificates of Deposit	☐Yes	☑No
Checking Accounts	☑Yes	☐No	Funeral Plans/Prepaid Burial	☐Yes	☑No
Savings Accounts	☐Yes	☑No	Burial Plots or Contracts	☐Yes	☑No
Credit Union Accounts	☐Yes	☑No	Stocks and Bonds	☐Yes	☑No
Annuities	☐Yes	☑No	Trust Funds	☐Yes	☑No
Government Bonds	☐Yes	☑No	Non-Home Place Property	☐Yes	☑No
Safety Deposit Box	☐Yes	☑No	Tax Refund	☐Yes	☑No
Retirement Accounts	☐Yes	☑No	Home Place Property	☐Yes	☑No
Vehicles	☐Yes	☑No	Life Insurance	☐Yes	☑No
			Other Resources	☐Yes	☑No

If you answered yes to any of these questions, please describe below and provide proof.

Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.
Checking Acct	569852	620	Washington Mutual

Form 222 (Rev 11/08)

8. **Income and Earnings:** Check all income owned by you, your spouse, and your dependents, or any income jointly received with someone else.

Wages or Salaries	☐Yes	☑No	Tips or Commission	☐Yes	☑No
Disability or sick pay	☐Yes	☑No	Self-employment or Odd jobs	☐Yes	☑No
Unemployment Benefits	☐Yes	☑No	Severance Pay	☐Yes	☑No
Social Security Income	☑Yes	☐No	Interest or Dividends	☐Yes	☑No
Worker's Compensation	☐Yes	☑No	Veteran's Benefits	☐Yes	☑No
Pension or Retirement	☐Yes	☑No	Rental Property Income	☐Yes	☑No
Child support or Alimony	☐Yes	☑No	Military Allotments	☐Yes	☑No
Adoption Assistance	☐Yes	☑No	Foster/Relative Care Pay	☐Yes	☑No
Contributions from others	☐Yes	☑No	Other income (specify)	☐Yes	☑No

If you answered yes to any of these questions, please provide proof.
Complete the information below for every person with income:

Person with income	Source of Income	How often income received	Amount
Albert Baker	Social Security	Monthly	1164.50

9. Does anyone pay child or dependent care cost? ☐ Yes ☑No
Child's name: _____ Amount Paid: _____ How often paid: _____

10. Have you transferred or given away any assets or property in the past 60 months? ☐ Yes ☑No
If yes, explain: _____

IMPORTANT: If your benefits change as a result of this review, we will send you a notice explaining what will happen. If you do not agree with our decision, you can request a fair hearing.

- I understand that if I am not satisfied with the action taken on my case, I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the county office where I applied.
- I understand that any lump sum or "windfall" payment that any person in my Medicaid case receives must be budgeted, along with any other income that we might have, to determine eligibility.
- I agree to provide the county and/or representative of the Department of Human Resources information necessary for verifying any statement given on this form and hereby give permission to the same to obtain verification of such information if needed.
- 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 such as banks, saving and loan associations, credit reporting bureaus, and other county, state, and federal government agencies, including Internal Revenue Service, to verify eligibility for assistance.
- **Assignment of Rights of Payment for Medical Support and other Medical Care:** 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. (If you are completing this form 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 above as a condition of his/her eligibility for Medicaid.)

PENALTY WARNING

I understand that: If I give false information or withhold information, I may be prosecuted for fraud.
I must also report all changes in my situation within 10 days of becoming aware of a change.

TO THE BEST OF MY KNOWLEDGE, I SWEAR OR AFFIRM THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT.

SIGN, DATE AND RETURN THIS FORM BY THE DUE DATE ON THE FRONT OF THE FORM

YOUR SIGNATURE OR MARK: Albert Baker _____ 9/24/06 _____
Date

PHONE NUMBER: _____ **E-MAIL ADDRESS:** _____

SIGNATURE OF PERSON HELPING TO COMPLETE THIS FORM: _____ **DATE:** _____

DO YOU WANT THIS PERSON AS YOUR PERSONAL REPRESENTATIVE? ☐ Yes ☐ No

The Emory Clinic

Bill To:

Albert Baker
122 Bartlett Drive
Atlanta, GA 30301

Statement

Statement #: 2541

Date 9/30/06

Account #: 2563

DATE OF SERVICE	DESCRIPTION	AMOUNT	PAYMENT	BALANCE
7/19/06	Outpatient Surgery	2300.00		2300.00
7/19/06	Anesthesia	600.00		2900.00
7/22/06	Office Visit	75.00		2975.00
7/22/06	Doppler Echo P	63.00		3038.00
7/31/06	Patient paid		200.00	2838.00
TOTAL				2838.00

REMITTANCE:

Account #: 2563
Statement #: 2541
Date: 9/30/06

Amount Due: $2838.00
Amount Enclosed:_____

YOUR ACCOUNT IS PAST DUE!
Please send your payment immediately. Thank you! Please include the statement number on your check.

The Emory Clinic appreciates the opportunity to meet your health care needs.

The Emory Clinic
1104 Peachtree Street NE
Atlanta, GA 30303

Phone: 404 578-4213
Fax: 404 578-4215

LEE-KING PHARMACY

Pharmacy Receipt

Prescription #: REF # 478569
Date: 7/19/06

Price: $230.00

Patient Information:

Albert Baker
122 Bartlett Drive
Atlanta, GA 30301

Statement #: 2541

Date: 07/19/06 **PAID: $230.00**

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Contact Letter and Information/Verification Checklist for Aged, Blind, and Disabled Medicaid

_____ _____County DFCS

_____ _____ AU# _____

_____ _____ Date: _____

_____We received your Medicaid application/review. In order to make an eligibility determination on your case, we need the information or proof listed below. Failure to provide this by the time requested will result in closure of your case or denial of your application.

_____An interview is also required by phone **or** at your home **or** at our office. You are scheduled for a telephone/office interview on _____ at _____ with _____.

You may contact me at the phone number listed at the bottom of this letter. I can be reached _____ (days of week) between_____AM and_____PM.

We need the following by: _____

Written Proof:

_____Amount of monthly gross earnings for: _____
_____Declaration of Citizenship/Alien status
_____Social Security Number for: _____and copy of Medicare card.
_____Copies of bank statements: checking/savings, certificates of deposit, and any other investments
_____Copy of award letters for pension, retirement, disability, SSI, VA, Child Support
_____Workman's Compensation
_____Tag Receipt for vehicles
_____Copies of life insurance showing face value **and** cash value
_____Burial contract, burial funds, cemetery lots, burial designation form
_____Medical Records needed for disability determination
_____Copies of Medical Bills owed
_____Physicians Referral form, DMA 526 for Emergency Medical Assistance.
_____Health Insurance Information Questionnaire, DMA 285, completed and signed by:
_____
_____For Katie Beckett Deeming Waiver, psychological, DMA 6 completed by physician, care plan
Other: _____
_____Statement of shared household expenses
_____Proof you have applied for _____benefits.
_____Information on real property; deed or property tax statement.
_____Other: _____
_____

_____ _____ _____
Caseworker Name Caseload ID Direct Phone Number

Form 981 (Rev 11/08)

Georgia Department of Human Resources

Living Arrangement/In-Kind Support and Maintenance Development Guide and Summary

A/R Name:

Part A – Living Arrangement (Enter "Yes" or "No". When "Yes", STOP – LA Established – Continue…)

1. Is Institutionalized? _____ **LA-D** (NH, Hospital, CCSP, Hospice, TEFRA Waiver, ICWP, MRWP)

   STOP: Do not develop ISM for any month the Medicaid CAP is used to determine eligibility.
   Case Manager should sign form above Part F on next page.

2. Is a Transient? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

3. Lives Alone? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

4. Lives Only with Spouse and/or Minor Children and/or Deemor? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

5. Owns own home? _____ **LA-A**

   If an adult other than A/R's spouse lives in HH – Develop Inside ISM – Complete Part B, **AND** Develop Outside ISM – Complete PartC, Part D, Part E and Part F.

6. Has rental liability? _____ **LA-A**

   If an adult other than A/R's spouse lives in HH – Develop Inside ISM – Complete Part BI, **AND** Develop Outside ISM – Complete Part C, Part D, Part E and Part F.

7. Lives in a PA Household? _____ **LA-A**

   Develop Outside ISM – Complete Part C, Part D, Part E and Part F. Do **NOT** Develop Inside ISM.

8. Lives with others and separately consumes and/or purchases food? _____ **LA-A**

   Develop Inside ISM for shelter only – complete Part B **AND** Develop Outside ISM – Complete Part C.
   Also complete Parts D, E and F.

9. Lives with others and meets sharing? _____ **LA-A**

_____	%	_____	=	_____	_____
Total HH Expenses		Number in HH		A/R's Pro Rata Share	A/R's Contribution

   Does the individual pay his pro rata share of household expenses? (Or within $5.00 of his share?)
   Develop Outside ISM – Complete Part C, Part D, Part Eand Part F. Do NOT develop Inside ISM if sharing exists.

10. Lives with others and meets earmarked sharing? _____ **LA-A**

_____	%	_____	=	_____	_____
Food Expenses Only		Number in HH		A/R's Pro Rata Share	A/R's Contribution

   NOTE: A/R must pay at least pro rata share – no $5.00 tolerance.

_____	%	_____	=	_____	_____
Shelter Expenses Only		Number in HH		A/R's Pro Rata Share	A/R's Contribution

   NOTE: A/R must pay at least pro rata share – no $5.00 tolerance.

   Does the individual earmark his contribution for food **OR** shelter? _____
   If "Yes", Develop Inside ISM for Food **OR** shelter – Complete Part B **AND**
   Develop Outside ISM – Complete Parts C, D and F.

11. Is subject to VTR? _____ **LA-B**

   A/R lives in the HH of another and is furnished food **AND** shelter by adult HH members other than spouse.
   Use FBR for LA-B. Do **NOT** develop ISM further – Complete Part E.

Form 969 (R. 10/06)

Georgia Department of Human Resources

Part B – Inside ISM	Individual/Individual with Ineligible Spouse	Couple
Total HH Expenses **PAID** by HH Members	_____	
Divide by # of HH Members	÷ _____	
A/R's pro rata share	= _____	
Deduct A/R's Contribution	- _____	
Actual value of Inside ISM	= _____	

Part C – Outside ISM		
Total HH Expenses PAID by non-HH members	_____	
Divide by # of HH Members	÷ _____	
Actual value of Outside ISM	= _____	

Part D – Total ISM (Inside and Outside ISM)			**Cash to A/R with O.I. or R. L.**		
Inside ISM (Part II)		_____	Cash Contributions		_____
Outside ISM (Part III)	+	_____	HH Expense	-	_____
Total ISM (Actual Value)	=	_____	Cash Contribution	=	_____
Chargeable ISM – Limited to PMV		_____	O.I. – Ownership Interest R.L. – Rental Liability		

Part E – Summary

_____ The one-third reduction does NOT apply because _____

LA –A. Chargeable ISM? $ _____. Cash Contribution? $ _____.

_____ The one-third reduction applies because _____

LA – B. Do NOT put any ISM in the Budget.

MES Signature _____ Date: _____

Part F – Household Expenses (To be completed by A/R or personal representative)

Work space for computing HH Expenses:

1. To determine if sharing or earmarked sharing exists, and
2. When developing **INSIDE** ISM

(Use only those amounts paid by the HH for **INSIDE ISM, SHARING, OR EARMARKED SHARING**. If not paid or paid by someone outside the HH, **USE ONLY FOR CONSIDERATION OF OUTSIDE ISM** .)

HH EXPENSES **The ONLY HH Expenses to be considered:**	**TOTAL HH MONTHLY EXPENSE AMOUNT**	**AMOUNT PAID BY PEOPLE WITHIN THE HOUSEHOLD**	**AMOUNT PAID BY PEOPLE OUTSIDE THE HOUSEHOLD**
Food (**DO NOT** count, if earmarked sharing for shelter)			
Mortgage (Including insurance required by mortgage holder)			
Rent (**DO NOT** count, if earmarked sharing for food)			
Real Estate Property Taxes			
Heating Fuel (Other than gas or electricity)			
Gas			
Electricity			
Water			
Sewer			
Garbage Removal			
TOTAL			

I verify that the above is a true representation of my household expenses and what I (and my spouse) pay toward these expenses.

Signature of Applicant/Recipient or Authorized Representative: _____ Date: _____

Signature of Person Paying Remainder: _____ Date: _____

Form 969 (R. 10/06)

Section D

Complete ONLY for Spend-Down Cases Budget Period _____ Through _____
Mo/Day/Yr Mo/Day/Yr

DOCUMENTATION OF INCURRED MEDICAL EXPENSES								
			4. Medical Expenses				5. Income Excess $____	6. Future Spend-down Medical Deduction
1. Incurred By:	2. Type of Bill	3. Method of Verification	Date Incurred	Amount	Paid Unpaid (P/U)	Amount Applied		

Section E

Disposition:

□ Approval: Medical "Begin Authorization Date" From _____ Through _____
Mo/Day/Yr Mo/Day/Yr

☐ Rejected: Never met deductable

Notifications:

□ To DMA Via SUCCESS on _____ Client is obligated to pay $ _____ toward Spend-down

☐ To Client via Notification Form. You are obligated to pay $ _____ toward spend-down for _____
Mo/Day/Yr

_____
Signature of Worker Date

Form 238 (R. 04/04)

```
CHANGE             NON-FINANCIAL ELIGIBILITY RESULTS - ELIG          ELIG    A
  Month 11 06                                                          01

 AU ID 175700040    Prog MA    Prog Type D    Med COA S99
 Confirm y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date     Date     Date     Date    Type  End Date
  M    347           050106   050106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T  Date
 ALBERT BAK   SE OT        RE   A 100506 347  050106
```

```
CHANGE                 MA FINANCIAL ELIGIBILITY - MAFI               MAFI    A
  Month 11 06                    AUTO   10 05 06
 AU ID 175700040   Prog MA   Prog Type D        Med COA S99

 Resources                          Income Test Continued
   Resource Limit          2000.00   Allocated Income           .00
   Total Resources          620.00   Gross Unearned Income  1253.00
 Patient Liability/Cost Share        General Inc Deduction    20.00
   Pat Liability Income        .00   Net Unearned Income    1233.00
   Medicare Premium            .00   Gross Earned Income        .00
   Protected Income            .00   Earned Inc Deductions      .00
   Person Needs Allowance      .00   Net Earned Income          .00
   Diversion Amount            .00   Net Income             1233.00
   IME Amount                  .00   Income Limit            317.00
   Pat Liab/Cost Shar Amt      .00   Spenddown Amount        916.00
 Income Test                         Medical Expense Amt        .00
   Gross Deemor Income         .00   Net Spenddown Amount    916.00

 Bnft Eff Date 101206  Bnft Confirm y   Reasons                 Recon Ind
 Notice Type                Waive Timely Ntc  Period     Notice Override
 Review Begin Date 11 06    Review End Date 04 07        Strat 1
 Message

  13-note
```

```
CHANGE                INKIND SUPPORT & MAINTENANCE 2 - ISM2          ISM2    A
  Month 11 06

 AU ID 175700040    Prog MA      Prog Type D       Med COA S99



                  Cash Contribution Amount         .00

                  Inside   ISM Amount              .00

                  Outside  ISM Amount              .00

                  Total    ISM Amount              .00




 Message
```

```
CHANGE                       SESSION SUMMARY - DONE                    DONE
  Month 11 06                                                             01



   AU ID   Prog  Med COA    Elig   - Status -   - Benefit --   Outstanding
                            Req    Code Cfirm    Amt   Cfirm  Verifications
 175700040 MA      S99       Y      M     Y              Y



 Message 1351
 1351 DOES THIS AU NEED "SPENDDOWN AUTHORIZATION"?
                                       16-prwp  20-edd  21-narr
```

```
INQUIRY                SPENDDOWN MEDICAL EXPENSES - SDME            SDME 01
  Month 07 06                     0171   10 05 06                      01

 HOH Name    ALBERT         BAKER                Client ID 510000046
 AU ID 151000040

 Del  Expense    Amt   V        Date          TPL     A/R   Exp Pd   SD
      Covered                 Incurred        Amt     Bill  Rollover Use
       Y      88.50    OT     07 01 06                 Y       U
      Provider Name SOCIAL SECURITY            Exp Typ N    CL ID 510000046
       Y      230.00   BI     07 19 06                 Y       P
      Provider Name LEE-KING PHARMACY          Exp Typ P    CL ID 510000046
       Y     2900.00   BI     07 19 06                 Y       U
      Provider Name The Emory Clinic           Exp Typ N    CL ID 510000046
       Y      138.00   BI     07 22 06                 Y       U
      Provider Name The Emory Clinic           Exp Typ N    CL ID 510000046

      Provider Name                            Exp Typ      CL ID

                             Client Liability Amt for Breakeven Bill
                                                              More Med Exp
 Message

                 15-lett                                                24-deL
```

```
INQUIRY                    SPENDDOWN DEDUCTIBLE - SDDE                SDDE
  Month 07 06                     0171   10 05 06

 HOH Name ALBERT         BAKER                     Client ID 510000046
 AU ID 151000040



                                Spenddown Amount     916.00
                          Total Medical Expenses    3356.50
                     Remaining Spenddown Deductible       0.00









 Message
```

```
INQUIRY                SPENDDOWN MEDICAL EXPENSES - SDME             SDME 01
  Month 07 06                     0171   10 05 06                       01

 HOH Name    ALBERT         BAKER                 Client ID 510000046
 AU ID 151000040

 Del  Expense    Amt   V        Date          TPL     A/R   Exp Pd   SD
      Covered                 Incurred        Amt     Bill  Rollover Use
       Y         88.50 OT     07 01 06                 Y       U      U
      Provider Name SOCIAL SECURITY            Exp Typ N    CL ID 510000046
       Y        230.00 BI     07 19 06                 Y       P      U
      Provider Name LEE-KING PHARMACY          Exp Typ P    CL ID 510000046
       Y       2900.00 BI     07 19 06                 Y       U      B
      Provider Name THE EMORY CLINIC           Exp Typ N    CL ID 510000046
       Y        138.00 BI     07 22 06                 Y       U      N
      Provider Name THE EMORY CLINIC           Exp Typ N    CL ID 510000046

      Provider Name                            Exp Typ      CL ID

                              Client Liability Amt for Breakeven Bill    597.50
                                                                 More Med Exp
 Message

                 15-lett                                                24-deL
```

SUCCESS Participant Guide

Case Maintenance

Objectives

Participants will be able to:

- ✓ identify basic case maintenance tasks.
- ✓ discuss basic case maintenance concepts.
- ✓ process changes in a family's circumstances that may impact eligibility.
- ✓ process a transfer to a new nursing home.
- ✓ terminate an AU's case due to death of the recipient.
- ✓ extend a limited stay date.

Outline

I. Introduction

II. Mary Ellen Smith—Transfer From One NH to Another

III. Mary Ellen Smith—Recipient in NH Dies

IV. Marvin Franklin—Extend a Limited Stay

V. Review

Mary Ellen Smith
Transfer from NH to NH

Background: Ms. Mary Ellen Smith moved on 10/5/06 from Oak Manor NH to Bayview NH.

Your Assignment: Update her case to reflect her new nursing home.

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY: Oak Manor

CITY:

MEDICAID PROVIDER NO.:

SOCIAL SECURITY NO.: 200-01-XXXX

RECIPIENT'S NAME: Mary Ellen Smith

RECIPIENT'S MEDICAID NO.:

PRIMARY ICD-9-CM: 401.9

SECONDARY ICD-9-CM:

DATE OF BIRTH: 07-10-33 (M M D D Y Y)

SECTION II - ADMISSION

LEVEL OF CARE:
- 1-Skilled
- 2-IC
- 3-IC/MR

PATIENT ADMITTED FROM:
- A-Hospital
- B-Nursing Facility (NF)
- C-State Instit.
- D-Own Home
- E-Other _____
- F-SNF Medicare

ADMISSION DATE: M M D D Y Y

VA AID & ATTENDANCE INCLUDED: ( )Yes $_____ ( )No

DMA - 6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE:
- 1-Skilled
- 2-IC
- 3-IC/MR

LOC EFFECTIVE DATE: M M D D Y Y

VA AID & ATTENDANCE INCLUDED: ( )Yes $_____ ( )No

DMA - 6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME

SECTION IV - TERMINATIONS

REASON: F
- E - INELIGIBLE
- F - DISCHARGED
- G - DIED

EFFECTIVE DATE: 10-05-06 (M M D D Y Y)

DISCHARGE DESTINATION: C
- A-Home with a Health Plan
- B-Hospital
- C-Nursing Facility (NF)
- D-Other _____
- E-Own Home
- F-SNF Medicare
- L-Limited Stay Expired

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator X William Sykes

DATE: 10-05-06 (M M D D Y Y)

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X _____

County Code

DATE: M M D D Y Y

DMA - 59

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY: Bayview NH

CITY:

MEDICAID PROVIDER NO.:

SOCIAL SECURITY NO.: 200 01 XXXX

RECIPIENT'S NAME: Mary Ellen Smith

RECIPIENT'S MEDICAID NO.:

PRIMARY ICD-9-CM: 401.9

SECONDARY ICD-9-CM:

DATE OF BIRTH: 07 10 33 (M M D D Y Y)

SECTION II - ADMISSION

ADMISSION DATE: 10 05 06 (M M D D Y Y)

LEVEL OF CARE: 1 (1-Skilled, 2-IC, 3-IC/MR)

PATIENT ADMITTED FROM: B (A-Hospital, B-Nursing Facility (NF), C-State Instit., D-Own Home, E-Other_____, F-SNF Medicare)

VA AID & ATTENDANCE INCLUDED: ( )Yes $ _____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: (M M D D Y Y) THRU (M M D D Y Y)

PATIENT INCOME:

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE: (1-Skilled, 2-IC, 3-IC/MR)

LOC EFFECTIVE DATE: (M M D D Y Y)

VA AID & ATTENDANCE INCLUDED: ( )Yes $ _____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: (M M D D Y Y) THRU (M M D D Y Y)

PATIENT INCOME:

SECTION IV - TERMINATIONS

REASON: (E-INELIGIBLE, F-DISCHARGED, G-DIED)

EFFECTIVE DATE: (M M D D Y Y)

DISCHARGE DESTINATION: (A-Home with a Health Plan, B-Hospital, C-Nursing Facility (NF), D-Other_____, E-Own Home, F-SNF Medicare, L-Limited Stay Expired)

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator X Francis Potter

DATE: 10 05 06 (M M D D Y Y)

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X _____

County Code

DATE: (M M D D Y Y)

DMA - 59

HISTORICAL MONTH (10/06)

AMEN:

- Select R
- Type Ms. Smith's L01 AU ID number
- Type benefit month 10/06
- Press Enter

ADDR:

- Document on NARR
- Fastpath to INST

INST:

- Type Ms. Smith's Discharge Date and Payment Termination Date from old NH
- Change the Reason code to "C" for discharging to another NH
- Use the PMEN menu (PF16) to obtain Bayview NH Provider ID & address (write it down)
- Enter the new NH information on the next line
- Document on REMA
- Fastpath to DONE

```
CHANGE                          INSTITUTION - INST                      INST 01
Month 10 06                       9991   10 05 06                        01

Client Name MARY ELLEN     SMITH                 Client ID 949000001


D Inst   Provider   Admission Discharge  NH     LOC  V   Payment   - Payment -
   Type      ID        Date      Date   Perdiem  Auth    Auth Date  Term DT Rsn
  NH 000083047A      10 03 06 10 05 06     ?       S OT    10 03 06 10 05 06 C
  NH 000893161048    10 05 06                      S OT    10 05 06 02 02 20 L


  Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
  Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V
                                                                  50.00     BE

  Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met             Ind
                                                   Y      NH 401.9    N
                                                           More Institutions
Message 0483 01   0779 01
0483 VENDOR NUMBER DOES NOT CORRESPOND TO THE INSTITUTION TYPE CODE
              15-lett 16-pmen                                            24-del
```

ELIG:

- Review the data and confirm

MAFI:

- Review the data and confirm

ONGOING MONTH

AMEN:

- Delete Benefit month
- Press Enter

ADDR:

- Change address from Oak Manor NH to Bayview NH

PREV:

- Enter the Oak Manor NH address
- Fastpath to INST

INST:

- Enter the same information you entered for October, discharging from 1st NH and admitting to the 2nd NH.
- Fast path to Done

ELIG

- Review the data and confirm

MAFI

- Review the data and confirm

Mary Ellen Smith
Death of a Recipient

Background: Ms. Mary Ellen Smith, a resident of Bayview Nursing Home, has passed away. The nursing home has provided a DMA-59 indicating her date of death.

Your Assignment: Update her case to reflect her death.

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY: Bayview NH

CITY:

MEDICAID PROVIDER NO.:

SOCIAL SECURITY NO.: 200 01 XXXX

RECIPIENT'S NAME: Mary Ellen Smith

RECIPIENT'S MEDICAID NO.:

PRIMARY ICD-9-CM: 401.9

SECONDARY ICD-9-CM:

DATE OF BIRTH: 07 10 33 (M M D D Y Y)

SECTION II - ADMISSION

ADMISSION DATE (M M D D Y Y)

LEVEL OF CARE: 1-Skilled, 2-IC, 3-IC/MR

PATIENT ADMITTED FROM: A-Hospital, B-Nursing Facility (NF), C-State Instit., D-Own Home, E-Other_____, F-SNF Medicare

VA AID & ATTENDANCE INCLUDED: ( )Yes $ _____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME:

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE: 1-Skilled, 2-IC, 3-IC/MR

LOC EFFECTIVE DATE: M M D D Y Y

VA AID & ATTENDANCE INCLUDED: ( )Yes $ _____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME:

SECTION IV - TERMINATIONS

REASON: E-INELIGIBLE, F-DISCHARGED, G-DIED: G

EFFECTIVE DATE: 10 05 06 (M M D D Y Y)

DISCHARGE DESTINATION: A-Home with a Health Plan, B-Hospital, C-Nursing Facility (NF), D-Other_____, E-Own Home, F-SNF Medicare, L-Limited Stay Expired

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator X Francis Potter

DATE: 10 05 06 (M M D D Y Y)

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X _____ County Code

DATE: (M M D D Y Y)

DMA - 59

AMEN:

- Select R
- Type Ms. Smith's L01 AU ID number
- Type benefit month 10/06
- Press Enter

ADDR:

- Document on NARR
- Fastpath to DEM2

DEM2:

- Type Ms. Smith's date of death
- Document on REMA
- Fastpath to INST

```
CHANGE                    CLIENT DEMOGRAPHIC 2 - DEM2                DEM2 01
Month 10 06                     8991   10 05 06

Client Name MARY ELLEN     SMITH                 Client ID 949000001

Citiz V  Student V  High Grade V Striker ---Immunization --  Law -Health Chk -
           Stat      Completed     Stat   Curr GCse Due Dt   Brkr Ref   Date
   C   BC                           N

TPL  TPL   V  ------ Medicare -----    ------  Disability / Incapacity ------
      Coop     Entitlmnt   Claim Num    Disab  Approval Begin Date  End Date
                                        Type   Source   (MM YYYY)   (MM YYYY)
  N    C   CS     Y       200019999A      H      RS      01 2003

Joint  Vet   Military    Death   TANF Cap Parent ------ TANF Cap Child ----
SSI/FS Stat  Serv Num    Date     Ctr  End Date  Parnt ID Rcv Mo Cncpt GCse
         N              10 05 06

Non-Custodial Parent?    V


Message

               15-lett                                    22-tpl 23-alau
```

INST:

- Type Ms. Smith's date of death as the Discharge Date and Payment Termination Date
- Change the Reason code to reflect death
- Document on REMA
- Fastpath to DONE

```
CHANGE                        INSTITUTION - INST                      INST 01
Month 10 06                     9991   10 05 06                        01

Client Name MARY ELLEN     SMITH                 Client ID 949000001


D Inst   Provider   Admission Discharge  NH     LOC  V   Payment   - Payment -
   Type      ID        Date      Date   Perdiem  Auth    Auth Date  Term DT Rsn
  NH 000893161048    10 03 06 10 05 06     ?       S OT    10 03 06 10 05 06 G




  Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
  Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V
                                                                  50.00     BE

  Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met             Ind
                                                   Y      NH 401.9    N
                                                           More Institutions
Message 0483 01   0779 01
0483 VENDOR NUMBER DOES NOT CORRESPOND TO THE INSTITUTION TYPE CODE
              15-lett 16-pmen                                            24-del
```

ELIG:

- Review the data and confirm

MAFI:

- Review the data and confirm

Note: For the month of October, the case should remain "Active"

ONGOING MONTH

- Complete the same process for November

Note: For the month of November the case should close

MARVIN FRANKLIN
EXTEND A LIMITED STAY

Background: A new Hospice Care Communicator is received for Mr. Franklin extending his certification period for Hospice.

Your Assignment: Update his termination date for Hospice.

HOSPICE CARE COMMUNICATOR (STATUS CHANGE)

TO: Coweta DFCS (County Office of Department of Family and Children Services)
or
_____ (Hospice Care Agency)

FROM: _____ (County Office of Department of Family and Children Services)
or
VistaCare (Hospice Care Agency)

RE: Marvin Franklin / _____
Member Name — Medicaid ID #

555-55-XXXX
Social Security Number

(To be completed by Hospice Care Agency)
The following change has occurred in the above-named member's situation:

[ ] The member expired on _____
(date of death)

[ ] The certification period for the member expired effective _____ and the member is not electing continued hospice care.
(date m/d/y)

[✓] The certification period for the member expired effective 12/13/06 and the member elects to continue hospice care services for another certification period. The certification period extends from 12/14/06 through 3/12/07
(date m/d/y) (date m/d/y)

[ ] The member revoked the election of hospice care for the remainder of the election period. The effective date of revocation is _____
(date m/d/y)

[ ] The member transferred to another hospice care agency on _____
(date m/d/y)
The name and address of the other hospice care agency is _____

[ ] The member has been discharged/decertified from the election of hospice for the remainder of the election period. The effective date of discharge/de-certification is _____
(date m/d/y)

[ ] Other: _____

Brenda Harris — 12/15/06
Signature of Director — Date

Rev.6/06 DMA-528

SUCCESS Crossword

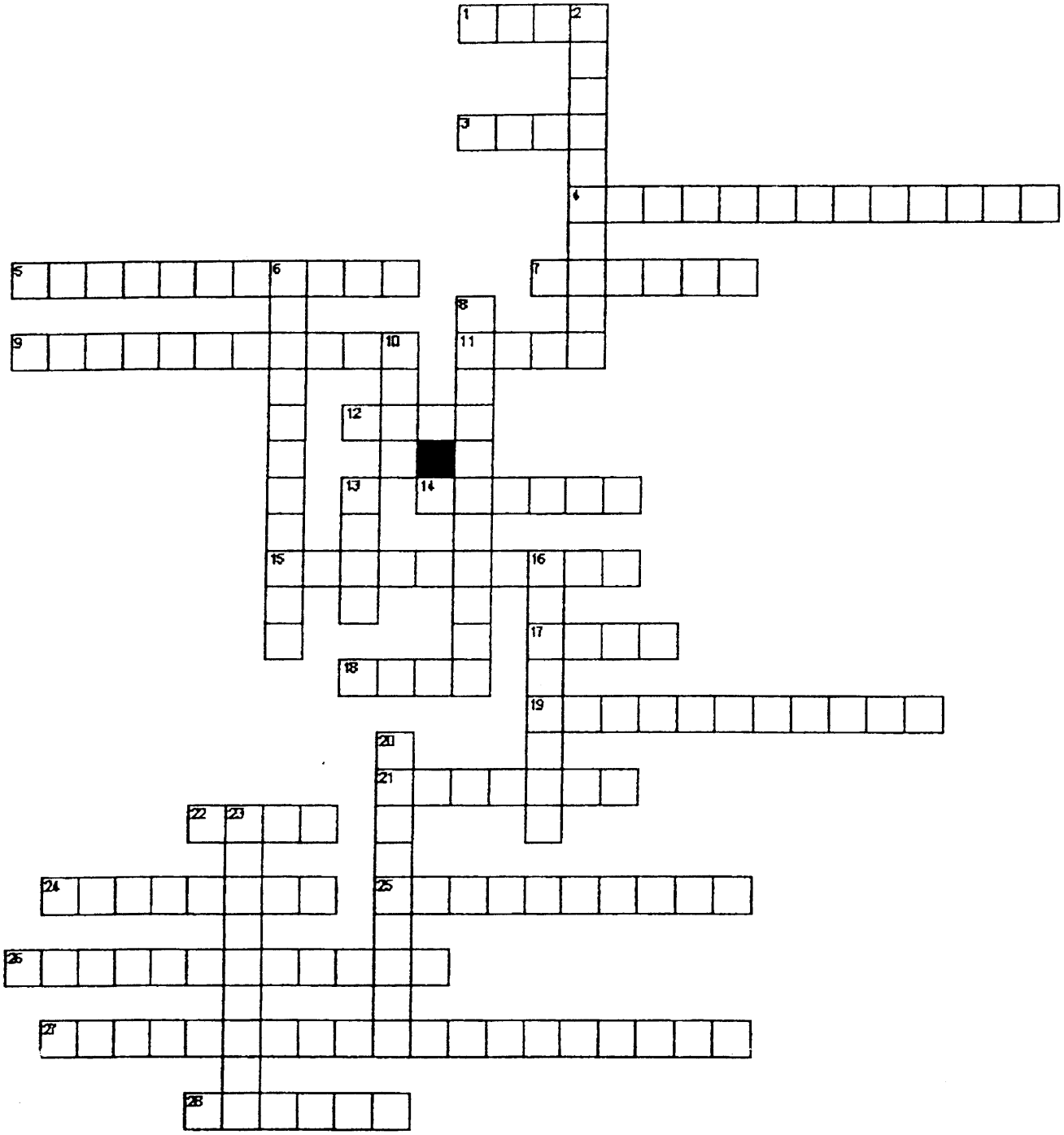
Across

1. The screen on which a former address is entered
3. Unearned income code of SA
4. VERF screen appears when there are outstanding _____
5. In registration, the PF18 key will take you to this function
7. The ALAS screen is where data concerning this group of people is entered
9. Entering an incorrect suffix in this field on the PLAW screen may cause the AU to close or trickle inappropriately
11. If an A/R has multiple unearned income types, a Y entered in this field will cause another UINC screen to appear
12. Prior months Medicaid is selected from this screen
14. The system will automatically schedule this annually
15. Changes made to an AU are either in the on-going month or the _____ month
17. Information concerning LA-D COAs is entered on this screen
18. Medical costs for FS are entered on this screen
19. L01 is the SUCCESS code for this COA
21. AU status of P
22. A replacement Medicaid card may be printed from this screen
24. L02 is the SUCCESS code for this COA
25. This group of fields must be completed on DEM2 if an A/R is not aged
26. An interview appointment may be scheduled during this process
27. If an A/R wishes to apply for the Q Track, this option should be selected from the CIRC screen
28. Case status of D

Down

2. The term used for a code entered in a field
6. Type of information entered on DEM1 and DEM2
8. If a worker causes a delay in processing a QMB AU, use of this field on the MISC screen will result in allowing a different eligibility begin date
10. Screen where documentation is entered
13. You indicate a review is complete on this screen
16. This should always be reused if an A/R is known to the computer system
20. Case status of M
23. A review is either standard or _____

SUCCESS



SUCCESS Participant Guide

Add-A-Program

Objectives

Participants will be able to:

√ Determine when and if a program should be added to an existing AU

√ Determine the correct COA for the new program

√ Request forms and verification, if needed for the new program

√ Complete the add a program in SUCCESS

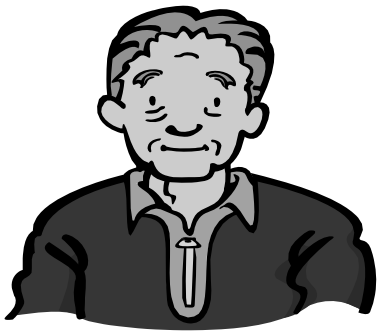
Outline

I. Introduction

II. Jonathan Daniels – Walk Through

III. Review

Jonathan Daniels
Add- A- Program



Background: Nathan Daniels**,** Jonathan Daniels' son, makes an office visit on 10/3/06 to report that his father has been placed in a nursing home. His father's health has deteriorated and he needs full-time care. His father entered Oak Manor Nursing Home on 10/03/06. Nathan will be the PR for Mr. Daniels case, his address is 522 Lakeside Drive, Atlanta, GA 30303. His phone number is 404 989-2323. He brings a statement from his father indicating that he wishes to name his son, Nathan, as PR.

Your Assignment: Register, interview, complete the application processing and finalization functions to add Nursing Home Class of Assistance to Mr. Daniels' case.

STEP 1: REGISTER NEW PROGRAM

AMEN

- Select L
- Enter Mr. Daniels' Q03 AU ID **XXXXXXXXX**

NAME

- Cannot change any information, press ENTER

KIND

- Place a Y to select Aged Blind Disabled Medicaid
- Press ENTER

CIRC

- Select Nursing Home
- Select Authorized Rep
- Press Enter

MEMB

- Cannot change any information, press ENTER

INCH

- Select L01
- Enter application date of 10/03/06
- Print AFA as this is a new application
- F4 around the warning message

REDI

- Do not schedule an appointment, PF4

STEP 2: INTERVIEW

AMEN

- Select “O”
- Enter Mr. Daniels’ L01#.

ADDR

- F21 to enter the following remark on NARR:
- Nathan Daniels**,** Jonathan Daniels son, made an office visit on 10/3/06 to report that he placed his father in Oak Manor Nursing Home on 10/3/06. His father’s health has deteriorated and he needs full-time care. Nathan states that he is his father’s authorized representative.
- Change Jonathan Daniel’s address to that of the Nursing Home:

  Oak Manor Nursing Home
  2010 Warm Spring Road
  Columbus, GA 31904
  (Remember to write down the old address)

- PF4

PREV

- Enter residential address. He lived at this address from June 1985 to present; owns home

STAT

- Complete STAT and document the COA change on REMA.

DEM1

- Change Living Arrangement code to “NH”.

INST

- Complete INST using Form DMA-59.

Note: Do not Fast Path to Done

- Press Enter

ERRO (If you have no errors this screen will not appear)

- Display error codes and resolve.
- Stop and be sure to problem solve all errors.

ELIG

- Eligibility screens show due to change to active members in existing case.
- Check non-financial eligibility and confirm if correct.
- Press ENTER

MAFI

- Check and confirm income amount. It should not have changed.
- Press ENTER

DONE

- Complete and document on NARR your verification checklist and document any accompanying forms
- Press ENTER to commit data to data base

STEP 3: PROCESSING APPLICATION MONTHS

AMEN

- Select P and enter Mr. Daniels' L01 AU ID **XXXXXXXXX**

Note: Update all screens as though you are in the interview process for all historical months. SUCCESS will not copy back for historical months.

APP1

- Select 10/06
- Fast path to DEM1

DEM1

- Change to NH

INST

- Complete Screen

RES1

- Update verification fields (all resources must be verified for the NH case)

- Press ENTER

RES2

- Enter Homeplace information
- Fast path to DONE

UNIC

- Update verification code (all income must be verified for the NH case)
- Press ENTER

DONE

- Press Enter to commit to the data base

APP1

- F13 back to AMEN

STEP 4: FINALIZE

AMEN

- Select Q and enter Mr. Daniels' L01 AU ID **XXXXXXXXX**

APP2

- Press ENTER

ELIG B for 10/06

- Review and enter Y to confirm

MAFI for 10/06

- Review and enter Y to confirm

ELIG B for 11/06

- Review and enter Y to confirm

MAFI for 11/06

- Review and enter Y to confirm

APP2

- Enter Y to confirm

Register, Reopen, Add-a-Program

Screen ID	Register	Reopen	Add a Program
AMEN	Option J	Option A to get AU ID. Option J with AU ID	Option A to get AU ID Option L with AU ID
NAME	Worker enters all required data from scratch.	Worker can only change HOH address.	Worker cannot change any data.
KIND	Worker can select any program.	Does not appear, no selection is made.	Worker can select any program.
CIRC	Worker can enter any required data	Worker can enter any required data	Worker can enter any required data
MEMB	Worker completes one MEMB screen for each household member.	Screens come up prefilled with name clearance data; worker can only enter pregnancy data or add members.	Screens come up prefilled with name clearance data; worker can only enter pregnancy data or add members.
CRS Name/SSN Clearance	SUCCESS automatically checks CRS database to see if each new entered household member already exists; worker sees CRS Name clearance after each MEMB screen.	Worker may use CRS Name inquiry to find old AU ID or Client ID to reopen, but doesn't see CRS Name/SSN Clearance after each MEMB screen, since person already exists in system except for new AU members added during registration.	Worker may use CRS Name inquiry to find old AU ID or Client ID to reopen, but doesn't see CRS Name/SSN Clearance after each MEMB screen, since person already exists in system except for new AU members added during registration.
INCH	Worker can select any program.	Worker can select only closed or denied programs associated with the HoH's client ID. Exception: RSM Pregnant Woman can be done.	Worker can select any program. Worker can tab to next available field select and enter program MA COA.

Work Smarter

ALERTS

Training

Not Harder!

Participant Handbook
Phase II Training

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Welcome to Alerts Training!

Alerts are SUCCESS produced messages/reminders that require action or attention. When used correctly, alerts will enhance your ability to effectively manage your caseload. This two hour workshop is designed to reinforce as well as increase your knowledge of the Alert process. This participant handbook can be used to assist you with caseload management now and in the future.

OBJECTIVES

Participants will be able to:

- read and interpret an alert screen
- access alerts from designated SUCCESS screens
- identify the different types of alerts
- create worker generated alerts
- disposition alerts
- use alerts for effective caseload management

Alert Basics

Alerts are SUCCESS produced messages/reminders that require your action/attention. Alerts are attached to the AU and are sent to the caseload assigned to that AU. Case Managers should use their alerts to prioritize their work. Alerts notify the Case Manager of the actions needed and/or actions that SUCCESS performed during overnight batching.

TERMS	EXPLANATION
ALERT CODES	Each alert is assigned an alert code. The alert code identifies the alert to the system. Alert codes are assisgned a number from 001 to 999.
ALERT PRIORITY	Alert priority indicates the relative importance of the alert. Alert priorities are assigned numerically from 001 to 999.
PRIORITY ORDER	When you see alerts listed in priority order, you will usually see alerts with the lowest numerical value alert codes listed first, followed by the higher ones. Within each alert code, you will see the earliest due dates listed first.
DUE DATE	Each alert is assigned a due date. This date indicates when the work specified by the alert must be completed. For a worker-generated alert, the worker must enter this date.
DISPLAY DATE	Each alert is assigned a display date. For a worker-generated alert, the worker must enter this date. This date indicates when the system will display the alert.
SUMMARY GROUPS	A high-level classification for types of alerts, such as system maintenance or interface.

The alerts will appear in the following colors:

- **Hot Pink** means the alert is new today and has **NOT** been dispositioned.
- **Light Blue** means the alert has been on your alert listing more than one day and has **NOT** been dispositioned.
- **White** means you have just accessed that alert.
- **Yellow** means the alert has been transferred to another worker or you have dispositioned the alert today.

How to Read an Alert Screen

- Alerts are listed on two lines.
- The first line has the alert code, due date, AU or Client number, and message text.
- The second line has the name of the Head of AU or specific client being referred to if it is a system generated alert.

```
UPDATE                PRIORITY DETAIL LIST - ALPR          ALPR
                 Prg                  Load 000Z           001 More
 S   Cd   Due   Cd   AU/Client   Message Text                    D
     110  080706  FS   2826354967   Review Pending
     Ida Mae Customer
Message
13-tier 14-altr 15-amen 16-esme 17-svds 18-svqc
```

First Line

Second Line

Definition of Fields

"S" field - allows the worker to select a specific alert and use the PF keys at the bottom of the screen to find out more information or access the case.

"CD" field - lists the code of the alert. **Note:** All Alert Codes are listed, with an explanation, in the SUCCESS User's Manual.

"Due" field - lists the date the alert is due

"PROG CD" field - the program code for the AU/Client for which this alert is generated.

"AU/Client" field - the AU case number or client ID number for which

this alert is generated.

"MESSAGE TEXT" field - text for the alert. This tells you what action the system has taken on this AU or client, or it tells you what action you need to take to review eligibility for this AU or client.

"D" field - in the far right column, is the field where you disposition the alert. SUCCESS will automatically disposition some alerts while some will have to be manually deleted by the FICM. Note: The alert description in the User's Manual tells which is required for each alert.

Functions Located at the Bottom of the ALPR Screen

"13-tier" - you want to obtain more detailed information on a two-tiered alert, type "Y" in the "S" field that is on the same line as the alert and press the **F13 key**.

"14-altr" - Use Alert Transfer to transfer an alert to another load ID. **Only Supervisors are authorized** to transfer alerts. When an AU is transferred to another load ID, all current alerts are transferred automatically

"15-amen" - If you want to access a particular function that is listed on the **AMEN** screen, type the corresponding letter of the function in the "S" field that is on the same line as the alert then press **F15**. The system will transfer you to the function you entered for the AU or customer specified in the alert.

If you want to go from the alert into SUCCESS, place an "R" in the 'Select Field' and **F15**, this will take you to the ADDR screen, from there you can fast path to the appropriate screens. **This process will only allow you to work in the ongoing month**, therefore, if corrections need to be made in the current and/or historical months, you will have to make those corrections from the **AMEN** screen.

"16-esme" – to go into the Employment Services screens using the selections on PHME. If you want to access a particular function that is listed on the ESME screen, type the corresponding letter of the

function in the “S” field that is on the same line as the alert then press **F16**.

The system will transfer you to the function you entered for the AU or customer specified in the alert. This process will only allow you to work in the ongoing month.

“17-svds” - If you want to obtain more detailed information on Alert 156 “SVES Discrepancy” type a “Y” in the “S” field that is on the same line as the alert and press **F17**.

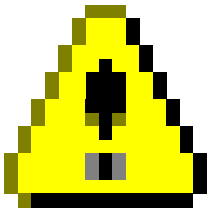
“18-svqc” - If you want to obtain more detailed information on Alert 157 “SVES Quarters of Coverage Have Been Returned”, type “Y” in the “S” field that is on the same line as the alert and press **F18**.

NOTES:

FOUR Types of Alerts

Worker Generated

Case Tracking Alerts



Transaction Alerts

Interface Alerts

Worker Generated Alerts

- Through direct entry, the FICM can create an alert for themselves and other case managers as a reminder of actions due on a specific case which are not system generated.

- This alert may also be used by Case Managers to communicate changes to other worker. Worker-generated alerts are assigned a medium level of priority.

- The alert codes used for worker-generated alerts are 450-489.

- Worker-Generated Alerts must be manually dispositioned by the receiver of the alert.

Example: If you have requested verification, you can create an alert to remind you of the date the verification is due.

The Create Worker-Generated Alert-ALWG screen displays the coding fields used to set up your alert. See sample screen below.

CREATE WORKER-GENERATED ALERT - ALWG ALWG

From Load ID **5648**

To Load ID **5648**

Client ID

AU ID **6548987512**

Alert Code **453**

Message Text **Elaine Johnson no longer employed , requested separation notice and last check**

Display Date **03/10/06**

Due Date **03/14/06**

Message

13-nmin 14-omen 15-next

Transaction Alerts

Transaction alerts are generated through batch processing and triggered by new data entered in the system, such as registering applications, interviews, reviews, various changes, financial exception transactions and transactions that are held incomplete or in error status.

Example: You register an application. During overnight processing, an alert will be generated to remind you that the application is pending and will give you a due date based on the standard of promptness (SOP) date for that specific program.

ALERT CODE	ALERT TEXT	
050	**Review Appointments Scheduled- Please Review**	**(W)**
	Appears the first day of the month that SUCCESS is up. Review schedule prior to notices being sent.	
051	**Review notices will be sent tonight**	**(S)**
	Generated the morning of the day on which review notices will be sent.	
102	**Application Pending**	**(S)**
103	**Verify the Application For or Receipt of SSN Applied For Date**	
106	**ABD Reconciliation – Perform Recon**	**(W)**
107	**Auto Review Processing Missed-FICM Initiate Review**	**(W)**
	When a case is approved after the 1st of the month, and a review is due the next month.	
110	**Review Pending**	**(S)**
111	**Retro Medicaid Pending (3 months prior)**	**(S)**
	Generated when a retro Medicaid month(s) were initiated but not finalized.	
112	**Extended MA AU Needs Review**	**(W)**
	Created when a case trickles to TMA and the MISC screen hasn't been completed by	
	placing a "Y" in the 'Extend MA COA" and the date is over 30 days old.	
114	**Child RSM Ineligible Due to Age- Complete DMD**	**(W)**
	Month before eligible child in F22 case turns age one, six or nineteen	
118	**Add-A-Person Pending**	**(S)**
120	**Spa On Hold** (Placed on Hold by Worker)	**(S)**
125	**Check 3 Month Prior Medicaid For AU**	**(W)**

	When application was registered and on the CIRC screen has a "Y" for prior 3 months.
126	**SPA Held For Work In Progress** (Placed on Hold by System) **(W)**
	Data held in the scratch pad because it couldn't be committed to the data base because it was missing info needed to satisfy final edits. This code becomes Alert 320 if case is still pending on SPA at the end of the month.
127	**This AU Has Not Been Transferred (W)**
	When a "Y" is placed on the AU's MISC screen under the "Auto Reassign Override".
133	**Complete CMD For Closed/Denied MA Adult (W)**
	Any adult client who has a TANF AU that trickled to F22 (RSM) or F99 (Medically Needy Spenddown) in the batch cycle
136	**SSN Match Found by Employee File (New Hire) (W)**
137	**SDX Shows Earnings but SUCCESS Does Not (W)**
202	**Application Registered-Interview Not Started (S)**
	AU registration is performed and neither the intake interview nor an interim change started
203	**Interview Not Started-Denial In 5 Days (W)**
	Generated 5 days prior to SOP. If action isn't taken on case by the end of SOP, SUCCESS will deny the application.
210	**Scheduling Conflict, Required Review Not Auto Scheduled (W)**
	Generated when there aren't any available appointments on your calendar from the 1st to the 15th of the month. You will have to set up the appointment.
212	**Pregnant Client Closed (W)**
	CMD needed for pregnant woman in a MA AU other than P01.
213	**RSM-Preg Ending for Woman Under 19-Review RSM Child (W)**
	When RSM Pregnant AU closes in batch and client is less than 19 years of age.
214	**Review Period Expired-EW Close AU (S)**
	ABD AU's POE ends today and a review has not been initiated.
217	**Review Mail-in Notice Sent (S)**
218	**This AU Has Been Transferred To This Load ID (S)**
219	**This AU Has Been Transferred From This Load ID (S)**
222	**Child Turning 16 Not a Student-Check Employment Services Status (W)**
	Generated in the month begin cycle one month prior to a non-student client achieving their sixteenth birthday
224	**Client Turning – Check School Attendance (W)**
226	**Client Becomes Age 19 or Age 18 And Is Not A Student (W)**

235	**Review Case Due to Excess Child Support From CSE**	**(W)**
236	**Pregnancy in 8th Month or Later-Check Status**	**(W)**
237	**Client In Employment Services Entering Subsidized Work**	**(W)**
238	**Client Penalty Expires This Month**	**(W)**
239	**Client in Employment Services Leaving Subsidized Work**	**(W)**
259	**Process Spenddown Authorization**	**(W)**
	When SD expenses were entered, current SD amount is zero, but authorization not performed.	
262	**RevIntevw Ntc Not Sent-EW Must Send Maint Intvw Ntc.**	**(W)**
	System schedules a combo review and the Case Manager reschedules one and deletes the other, the AU with the deleted appointment gets this alert.	
303	**AU selected For Mass Mod But No Updates Made**	**(S)**
	Generated when AU is chosen for mass modification but detects no case changes.	
304	**Appl Due-Enter Delay Rsn On Misc If Unable To Complete**	**(W)**
	If the AU is in pending status five days prior to the end of SOP and the intake interview has started. If the case goes OSOP, the MISC screen needs to be coded in the 'Delay Reason'.	
312	**Review Scheduled On Last Working Day Not Initiated Online**	**(W)**
314	**Review Discontinuance Warning Notice Sen**	**(S)**
	Generated for AUs one day after the review appointment was missed for a Standard (including when SUCCESS was down for the appointment). For alternates an alert is generated on the 6th day of the review month if the review hasn't been initiated.	
320	**Spa Deleted Overnight**	**(S)**
321	**Reinstatement Not Completed-AU Is Not Active**	
350	**AU Denied-Failure To Cooperate With Application Process**	**(W)**
351	**AU Discontinued Overnight**	**(W)**
353	**RSM Pregnancy Case Needs Due or TerminationDate**	**(W)**
377	**Client Discontinued Overnight**	**(W)**
388	**Client Sanctioned Overnight**	**(W)**
556	**Client No Longer Has Earned Income**	**(W)**
557	**Client's TANF Case Reopened**	**(W)**

This is not an all inclusive list!
Refer to the SUCCESS User Manual Appendix A for more Alerts Listings

Interface Alerts

- Interface alerts are generated by certain interface matches or exchanges. Interface matches/exchanges tell the Case Manager about discrepancies/errors in data entry.

- Some of Interface alerts are 'two-tiered' which means the Case Manager can use a Function Key to display an additional screen, which allows the Case Manager to compare interface data and system data.

- The Income and Eligibility Verification System (IVES) is a federally operated system through which agencies request personal data, wage and benefit information on applicants and recipients from other state and federal agencies.

- Primary social security numbers entered in SUCCESS are matched with the SSNs contained in these other agencies.

Example: The CSE interface may cause an update which generates an alert such as non-cooperation or excess support collections. The receipt of the SSN discrepancy from SSA generates an alert to investigate the discrepancy.

SUCCESS performs IVES computer matches with the following files from other agencies:

1. SSA Beneficiary Earnings Exchange Record System (BEERS)
2. United States Internal Revenue Service (IRS)
3. Interstate Files
4. SSA Prisoner Verification Inquiry
5. SSA Death Verification Inquiry
6. SSA Bendex
7. DOL wage files
8. Unemployment Compensation Benefit files (UCB)

Case Tracking Alerts

Case Tracking Alerts – SUCCESS examines certain cases for time-related activities and issues alerts, such as, disqualification, ES activities expiring, critical ages or reviews due.

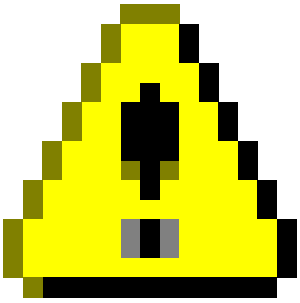
```
   UPDATE          PRIORITY DETAIL LIST - ALPR          ALPR
          Prg                                  Load 000Z          003 More
S  Cd   Due     Cd  AU/Client  Message Text                                                D
 103 082905 MA 121212121 VERIFY THE APPL FOR OR RECPT OF SSN    APPLIED FOR DAT
  GEORGIA CUSTOMER
  116 051305 MA 121212121 CHECK STUDENT STATUS-CHILD GRADUATING NEXT MONTH
  GEORGIA CUSTOMER
  212 110405 MA 121212121 PREGNANT CLIENT CLOSED
  GEORGIA CUSTOMER
  224 063005 MA 121212121 CLIENT TURNING AGE 18 - CHECK FOR SCHOOL ATTENDANCE
  GEORGIA CUSTOMER
  236 103105 MA 121212121 PREGNANCY IN 8TH MONTH OR LATER - CHECK STATUS
  GEORGIA CUSTOMER
  114 053005 MA 212121212 CHILD RSM INELIG DUE TO AGE - COMPLETE CMD
  GEORGIA CUSTOMER
  123 091205 MA 121212121 ENTER EXPENSES FOR MA SPENDDOWM
  GEORGIA CUSTOMER
  115 103105 MA 121212121 LIMITED STAY EXPIRING-REVIEW FOR CONTINUED ELIG
  GEORGIA CUSTOMER
  213 100305 MA 121212121 RSM-PREG ENDING FOR WOMAN UNDER 19 - REVIEW RSM CHI
  GEORGIA CUSTOMER

Message

13-tier 14-altr 15-amen 16-esme 17-svds 18-svqc
```

Example: If child is turning the critical age for ineligibility in TANF and you have not removed the child from the case, SUCCESS will:

- Remove the child
- Recalculate eligibility
- Send a notice to the A/R
- Generate an Alert to tell you what has been done

NOTES:

Caseload Management and Alerts



In order to effectively manage your caseload, Case Managers can use alerts to assist with everyday tasks. Alerts act as "reminders" for the Case Manager. The most effective way to use Alerts is to help manage your workload.

Alerts can be accessed from many of the SUCCEES screens where the **23-ALAU (press shift and F11)** appears at the bottom of the screen. These screens include ADDR, STAT, DEM1, DEM2, DEM3, RES1, RES2, ERN2, UINC, WORK, and MISC.

Alerts can also be accessed from the Main Menu, selection **"D"**, which will take you to the **Alerts Submenu – DMEN**.

SUCCESS allows you to view your alerts on any one of these four screens

ALERTS SUBMENU - DMEN **DMEN**

Selection

Load ID
AU ID
Alert Code
From Date
To Date

A. Create Worker-Generated Alert
B. Priority Detail List
C. Due Date Detail List
D. Assistance Unit Detail List
E. Load Alert Summary List
F. Supervisor Alert Summary List
G. Assistance Unit Detail List Archive

Message

Worker Generated Alerts, the Priority Detail List, the Due Date List, the Assistance Unit Detail Listing and the Load Alert Summary are excellent tools which can be used to prioritize your work.

Creating a Worker Generated Alert

Step 1 From the SUCCESS Main Menu, **Select "D"** for Alerts press enter

Step 2 From the Alerts Submenu - **DMEN type "A"** to select **Create a Worker-Generated Alert**; press enter

Step 3 Type data as follows in the required fields on the ALWG screen:

- enter your caseload ID number (from)
- enter the caseload ID number in which you want the Alert to appear
- enter Dawn Cosner's AU Number (XXXX00049) in the AU# field
- enter an alert code between 450 – 489
- enter message text
  Example: "Lee's separation notice and last 2 check stubs due Dawn Cosner"
- enter the date you want the text to display on your alerts
- enter the date the alert is actually due
- press enter

Using the Function Keys at the Bottom of the Screen

Press F13-nmiq to display the CRS Name/SSN Inquiry screen to locate a client ID. You can also find the AU's that are associated with that A/R.

Press F14-omen to look up a load ID number

Press F15-next to create another alert

DMEN

- select B - **Priority Detail List (ALPR)**
- press enter

PRIORITY DETAIL LIST - ALPR displays alerts by priority level from highest to lowest. A priority level from 001-700 is associated with each alert. **Use this alert listing as a prioritized "to do" list.**

Case Managers can go straight from this Alert screen to SUCCESS. The priority detail list screen can be accessed from most of the SUCCESS screens via a "function key'' located at the bottom of the screen

Utilizing your Priority Detail List would eliminate Case Managers from having to do worker cards (unless mandatory per Supervisor). **Working from the Priority Detail List-ALPR is one of the most effective approaches to managing your workload**

ALPR

- enter R next to the alert for Dawn Cosner
- press PF15
- PF4 around the REDE and ADDR screens
- Press enter at STAT A and STAT B.
- Stop at STAT C

NOTES:

STAT C

- press PF23 – **Assistance Unit Detail List (ALAU)**

ASSISTANCE UNIT DETAIL LIST - ALAU displays all the alerts associated with a specific AU. The display will show those alerts that are currently outstanding or have been dispositioned and not yet purged. This detail listing helps you to make certain that there are no outstanding alerts which might affect eligibility when you begin to update an AU. **Use this alert listing to get a picture of the AU activity.**

ALAU

- press enter to go back to STAT

STAT C

- fast path to ERN2 02
- press F9 to REMA
- document receipt of income verification
- fast path to DONE
- press enter

ALPR

- enter Y in the disposition field
- press enter
- Note: the color of the alert has now changed
- press enter again to return to DMEN

NOTES:

DMEN

- select C - **Due Date Detail List (ALDD)**
- press enter

DUE DATE DETAIL LIST – ALDD displays alerts chronologically by their assigned due date from earliest to latest. A due date is assigned to each alert. This date indicates when the work specified by the alert must be completed. **Use this alert listing as a pending and overdue "to do" list.**

ALDD

- press the Home key
- enter 10/15/06 in the "From Date" field at the top of the screen
- press enter
- press enter back to DMEN

DMEN

- select D - **Assistance Unit Detail List (ALAU)**
- enter Dawn Cosner's AU ID number (XXXX00049)
- delete 10/05/06 from the "From Date" field
- press enter

ALAU

- PF3 back to DMEN

NOTES:

DMEN

- select E – **Load Alert Summary List (ALWS)**
- delete the AU number
- press enter

LOAD ALERT SUMMARY - ALWS displays a numerical count of all outstanding alerts which are not yet due, coming due in seven days, and overdue by priority within an individual load ID. The display is organized by summary grouping. **Use this list to get a picture of your current caseload activity.**

On the **ALWS** screen, your alerts are grouped according to these summary groups:

- **100**-Pending applications
- **200**-Pending maintenance activity
- **300**-Pending redetermination
- **400**-AUs discontinued by batch
- **500**-Customer discontinued/disqualified in batch
- **700**-Employment Services

NOTE: These numbers, 100-700, are Summary Group Numbers, not Alert Codes.

F13-ALPR takes you to Priority Detail List
F14-ALDD takes you to Due Date Detail List

ALWS

- press enter back to DMEN

DMEN

Note: Alert Code – The alert code field can be used to list all pending alert codes of one specific type. You will enter either "B" or "C" and the alert code you want to list. For instance, if you would like to list all the pending reviews on your caseload, you would enter code 110. The system will list all of the 110 codes first, then the rest of the codes. This is an excellent tool to use to decide what actions need to be completed at a given time. If you decided that today you will work on pending applications, you would enter "C" for due date listing and alert code 102 to list all of your pending applications with the oldest application listed first.

- select B - **Priority Detail List (ALPR)**
- enter 561 for the alert code
- press enter

ALPR

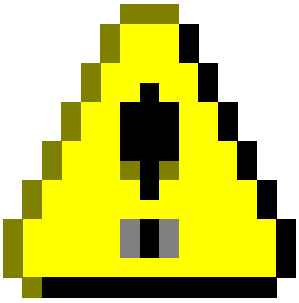
- press enter back to DMEN

DMEN

From Date – To Date

On DMEN notice that there is a field titled "From Date" and "To Date" where you can type in the current date or a future date and pull up alerts due in the future. This function can be used to look ahead and see what work is coming due. It would be helpful to use, for example, if you are planning a vacation and want to work ahead.

Alert Disposition



- **Disposition means that the alert is marked for removal**.

- Once you have completed the action called for by the alert, the alert is ready to be dispositioned.

- SUCCESS removes dispositioned alerts in an overnight batch run.

- You must disposition some alerts manually; others are dispositioned automatically by the system. (**see "alert text chart)**

The way an alert is dispositioned varies by the type of alert.

IF THE ALERT IS….	THEN THE ALERT…
worker generated	must be manually dispositioned by the receiver of the alert.
a one-day informational alert	will be automatically dispositioned the day after the display date.
a system-generated alert with action required.	may be manually dispositioned once the required action has been taken or will be automatically dispositioned once the required action has been taken.
a system-generated alert with no action required.	must be manually dispositioned by the receiver of the alert.

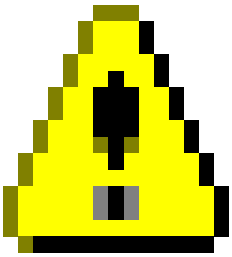
How to **Manually Disposition an Alert:**

```
UPDATE              PRIORITY DETAIL LIST - ALPR              ALPR
                 Prg                  Load 000Z              001 More
 S   Cd   Due   Cd   AU/Client   Message Text                  D
     110  080706  FS   2826354967   Review Pending              Y
     Ida Mae Customer
Message
13-tier 14-altr 15-amen 16-esme 17-svds 18-svqc
```

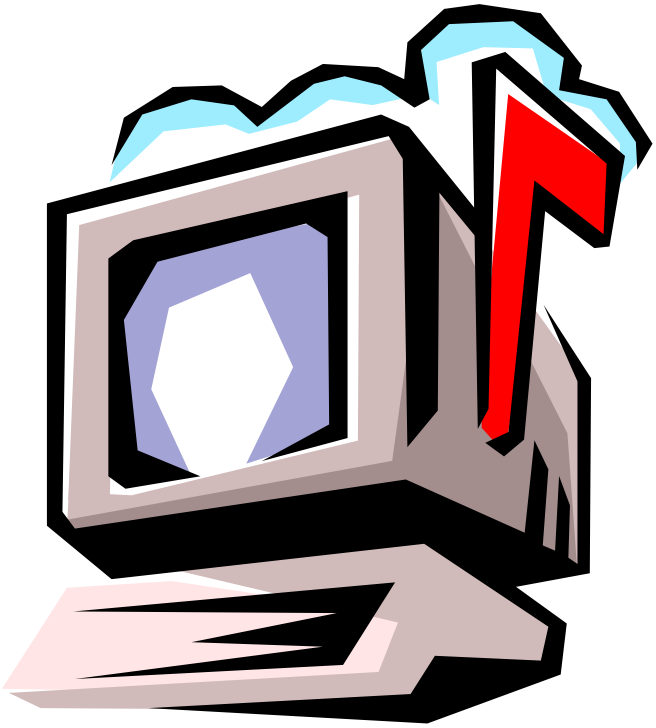
To disposition an Alert, enter a "Y" here and press enter. Make sure you have completed any necessary actions before you disposition an alert.

Tips for "ALERT" SUCCESS

- Each morning access your alerts via the Priority Detail List – ALPR.
- Use Worker Generated Alerts to track verification due dates.
- Once you have taken action on an alert, disposition it! Do Not Wait. The longer you wait the more alerts you will have to find time to disposition later.
- If time is limited, choose 2 days per month to disposition alerts. Once per week is even better!
- When completing changes or reviews, stop to access the alerts for the AU from any of the screens listed on page 16 of this handbook.
- Become familiar with the Alert Text on pages 10 - 12, this will make working with alerts much easier!



SUCCESS Participant Guide



Scheduling

SETTING UP YOUR WORKER CALENDAR

To set up a worker schedule refer to the SUCCESS User Manual (p 2.6-7). The following are hints to use while setting up your schedule.

You have a personal daily schedule which lists all your AU/Client appointments for a particular day. You identify the times you are available by blocking out periods of time for administrative reasons, vacations, lunch, or personal time.

You can schedule an appointment or block out schedules times:

- Up to eight weeks in advance
- For Monday through Saturday (SUCCESS does not automatically schedule appointments on Saturday
- In increments of 30 minutes, from 7:00 a.m. to 6:30 p.m., with the last appointment ending at 7:00 p.m.

On or about the 10th of the month, SUCCESS automatically deletes last month's schedule.

Worker Entered Appointment Type/Leave Codes

The following are codes which workers are able to enter on their schedule:

ADM – Administrative
AL – Annual Leave
CT – Compensatory Time
HV – Home Visit
LOA – Leave of Absence
LUN – Lunch
OL – Official Leave
PL – Personal Leave
*PT – Personal Time
SL – Sick Leave

All other valid values are appointment types which are system generated when an appointment is scheduled on REDI, MISC, PHOR or automatically scheduled in batch.

*Use Personal Time (PT) to mark off time slots in the daily schedule where you are not scheduled to be at work (times before/after your core work hours). When you mark off the times slots before you are to be at work, document this fact in the L. NAME/REMARKS field.

If there is not a specific code for the time that is being taken, use a code that makes the most sense. Document in the L. NAME/REMARKS field what the time is actually being used for.

Flex Days

Schedule flex days as follows:

Update your calendar for your normal work days.
Enter the date you flex in the date filed in the upper right hand corner of SCHD and hit enter.
Enter 'PT' in the 7:00 time slot and enter "Flex Day" in the L. NAME/REMARKS field.
Enter a "C" for appointment in every other time slot for that day.
Do this for each flex day.

Reviews

SUCCESS schedules review appointments in the last 5 working days of the month prior to the month in which the reviews are due and up until the 15th of the month in which the reviews are due. For example, reviews in which the Period of Eligibility ends on October 31, 2004 will be scheduled from September 27, 2004 through October 15, 2004. Leave enough slots available during these days for SUCCESS to schedule your reviews.

Sample Worker Schedule

The following is a daily schedule for a worker with core work hours of 8:00 am – 5:00 pm who takes lunch from 12:00 – 1:00. This worker also has a doctor's appointment scheduled for 8:00 am so they schedule one hour of sick leave from 8:00 until 9:00.

UPDATE			**DAILY SCHEDULE – SCHD**		**SCHD**
				FRIDAY	**Load ID 900A**
S	**Time**	**CL/AU**	**Appt**	**L. Name / Remarks**	**Date 05 22 04**
B	7:00		PT	Work Hours 8:00 – 5:00	
	7:30		C		
	8:00		SL	Drs. Appointment	
	8:30		C		
	9:00				
	9:30				
	10:00				
	10:30				
	11:00				
	11:30				
	12:00		LUN		
	12:30		C		
	1:00				
	1:30				
	2:00				
	2:30				
	3:00				
	3:30				
Message					
13-day+ 14-day-					

UPDATE			**DAILY SCHEDULE – SCHD**		**SCHD**
				FRIDAY	**Load ID 900A**
S	**Time**	**CL/AU**	**Appt**	**L. Name / Remarks**	**Date 05 22 04**
	4:00				
	4:30				
B	5:00		PT		
	5:30		C		
	6:00		C		
	6:30		C		

The "**PT**" indicates that the worker is on Personal Time. The "C" continues the Appointment Type to the next time slot. The "**B**" under the Selection filed blocks the time slot it is next to and carries it over from the day it is set until the end of the worker's calendar so that each day is set the same. To override the block, go to the specific day that needs to be changed and make any necessary changes.

SUCCESS Participant Guide

Closing

Objectives

√ Participants will be able to identify support tools available to assist with enhancing their knowledge of policy.

√ Participants will be able to identify the three most important aspects of their jobs.

√ Participants will be able to identify specific tasks that must be completed upon return to the county office.

√ Participants will be able to provide relevant feedback regarding the training session.

Outline

I. Overview

II. Additional Training

III. Conclusion

IV. Next Day Objectives

V. Feedback

VI. Closing

The DFCS Education and Training Website at:

www.dfcs.dhr.georgia.gov/training

- Click on New Office of Family Independence Case Manager Training
- Click on Resource Library
- Train Tracks, Job Aids and Self Studies are listed by program area

OR

The DFCS Online Training at:

www.gadfcs.org/training

- Select the program area you would like to review
- Select the stand-alone module or a module (book) within a course you would like to review

Conclusion

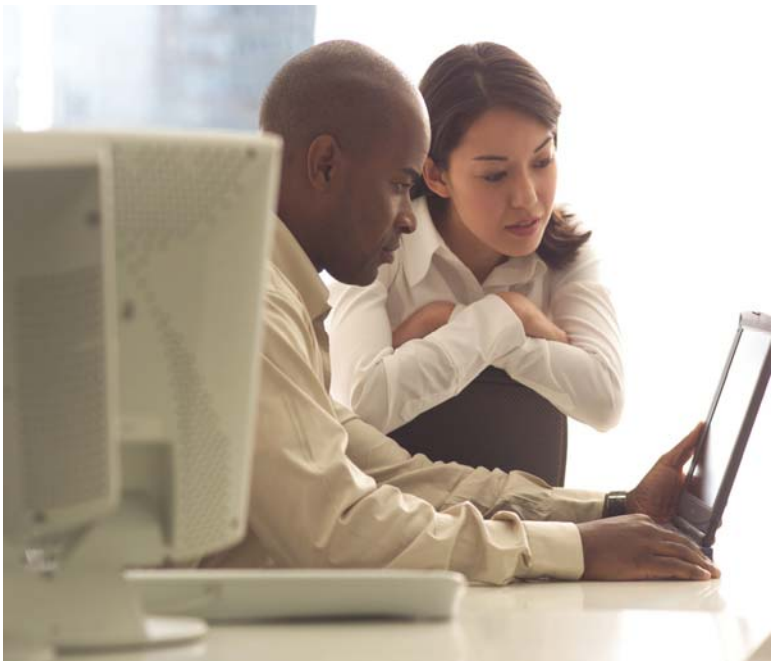
Now that you have completed training, in your opinion what are the three most important aspects of your job?

_____

_____

_____

_____



Next Day Objectives

Your next day of training will take place when you return to your county office. There are specific tasks that we encourage you to complete. It is to your advantage to complete these tasks within two weeks of returning to your office.

1. Ask your Supervisor about specific county procedures. Also ask any questions you have written on your Ask Your Supervisor list.

2. Make sure that you have MHN access and are trained in this area.

3. Contact your Community Resource Specialist to obtain a local resource handbook for your area. They should either already have one or can make one for you. This is also part of your networking. Don't forget we began the networking process in your training class. Obtain contact information from the rest of your training team before you leave class, or at least have everyone's name so you can keep in contact through GroupWise.

Thank you for being part of the team!
Congratulations!!!

SUCCESS Participant Guide

Desk Guide

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SUCCESS DOCUMENTATION

A thorough interview is the cornerstone of accurate casework. However, SUCCESS fields do not always capture all the aspects of an effective interview. It is necessary to DOCUMENT to accurately address all required elements.

The following pages contain guidelines to standardize **basic** documentation in SUCCESS. Basic documentation is the minimal "generic documentation" that is required on all cases. There are, however, no "generic cases". All cases are individual. Basic documentation addresses the elements shared by most cases. Additional documentation is usually required to address the unique aspects of each case.

General Rules

The purpose of documentation is to explain what SUCCESS cannot. When a SUCCESS field alone fully and clearly documents a situation, additional documentation is not required. It is not necessary to do "negative" documentation.

For example, there are multiple codes to document type of verification. "CS" for client statement, is usually a clear enough documentation of the source of verification. "TC" for telephone call would never, alone, be adequate for documentation.

Examples:

TC (telephone call)- requires documentation of the phone number called, the name of the person spoken to, the date of the contact and any other parts of the conversation that are relevant to the case.

OT (other)- requires documentation of the source of verification.

LE (letter)- requires documentation of who sent the letter.

Include additional documentation when required.

Identification

All documentation should start with the date of the action and include the case manager's last name and first initial and caseload number. Revenue Maximization Units should indicate the unit you work for (Rev Max Region V, Rev Max Intake Unit, etc.) A blank line should separate the documentation for each date.

HOUSEHOLD ADDRESSES
ADDR

```
INTERVIEW                 HOUSEHOLD ADDRESSES - ADDR                 ADDR 01
  Month 11 06                     0097   10 30 96

 CO 049  LO 049  Load ID 1065  Client ID 106594364  Prev CO/LO
 HOH F Name HERBERT        MI     L Name BLACK                 Suf

 Auth   Prim    Voter   Visually    Hearing     Public Hsng/  Serial   Census
 Rep    Lang     Reg    Impaired    Impaired    Rent Subsidy  Number   Tract
  N      E        N        N           N             Z
 Residential Address
 Address Line 1                         Line 2
 Street  Number  Dir          Name           Type    City Dir      Apt
           224        LINWOOD               AVE
 City ATLANTA                 ST GA   Zip 30301        Phone 404 657 0093

 Mailing Address   Del
 Address Line 1                         Line 2
 Street  Number  Dir          Name           Type    City Dir      Apt
                      SAME
 City                         ST      Zip
                                          Previous Addresses in last 2 years N
  Message 1881
 1881 STREET NUMBER OR BOX NUMBER NOT FOUND ON STREET
               15-lett                                 21-narr  23-alau  24-del
```

INFORMATION

It is important that addresses are entered correctly on the ADDR screen. SUCCESS compares addresses entered to the Code-1 Plus System for recognition of valid addresses. If an address is perceived as invalid, an error message will appear when the enter key is pressed. If the address is correct in spite of the error message, PF4 around the error message.

KEY FIELDS

Auth Rep: If the A/R has a personal representative, change the Auth Rep code from an N to a Y. This will cause a separate screen to appear where information concerning the personal representative may be entered.

Residential Address: Enter the Head of Household's residential address, even if it is a nursing home.

ADDR Screen (continued)

Mailing Address: If the HOH's mailing address differs from the residential address, enter that information in the mailing address fields. If the mailing address is the same as the residential address, no data should be entered here.

Previous Addresses in last 2 years: Enter a Y to access the PREV screen to enter information on former residences.

Document on NARR (F21 from ADDR)

- ✓ Application, review or change
- ✓ Type of contact
- ✓ Action being taken
- ✓ Initial conversation prior to starting the interview on SUCCESS
- ✓ The name of the person spoken to and that s/he is the best source of information
- ✓ Whether face to face, alternate or telephone interview
- ✓ A/R and authorized representative, if applicable were mailed HIPAA form and/or EMA notification form if form was not completed at interview
- ✓ If a SUCCESS letter template has been used, the date letter was written, type of letter template (ex. M400), Load ID and name of the worker using the letter template.
- ✓ For Medically Needy, actions taken and any pertinent information entered on SDME screen.
- ✓ Validity of QITs, when sent to DCH Legal, when returned & outcome, if applicable.
- ✓ For all L01 cases and W01 cases over 55- form DMA 315 Estate Recovery form was given, or document date sent if form was mailed

Document on ADDR (F9 from ADDR)

- ✓ Questionable mailing address
- ✓ Directions to A/R home, <u>if needed</u>

PREVIOUS HOUSEHOLD ADDRESSES PREV

```
INTERVIEW             PREVIOUS HOUSEHOLD ADDRESSES - PREV            PREV 01
  Month 11 06                                                           01

 HOH Name HERBERT        BLACK                   Client ID 106594364

 Del
 Address Line 1                          Line 2
 Street  Number   Dir          Name           Type   City Dir    Apt

 City                          ST      Zip
 From (MM YYYY)          To (MM YYYY)           Owned by Household Member

 Del
 Address Line 1                          Line 2
 Street  Number   Dir          Name           Type   City Dir    Apt

 City                          ST      Zip
 From (MM YYYY)          To (MM YYYY)           Owned by Household Member


                                                                More Addresses
  Message
```

INFORMATION

The purpose of this screen is to capture information about previous addresses within the last two years. It may also be used to show a history of the A/R's past residences.

NOTE: for Nursing Home AUs, always enter the A/R's residential address on PREV; enter the Nursing Home's address on ADDR.

AUTHORIZED REPRESENTATIVE
AREP

```
INTERVIEW              AUTHORIZED REPRESENTATIVE - AREP              AREP    A
  Month 11 06                                                          01

 HOH Name HERBERT         BLACK                 Client ID 106594364

 Rep Type      Relationship      Del
 F Name                MI     L Name
 Address Line 1                          Line 2 / Apt
 City                           ST      Zip              Phone

 Rep Type      Relationship      Del
 F Name                MI     L Name
 Address Line 1                          Line 2 / Apt
 City                           ST      Zip              Phone

 Rep Type      Relationship      Del
 F Name                MI     L Name
 Address Line 1                          Line 2 / Apt
 City                           ST      Zip              Phone

                                                                        More
 Message

                                                                         24-del
```

INFORMATION

Complete an AREP screen for each AU in which there is a personal representative. For example, if there is a Medicaid AU and a FS AU, personal representative information must be entered on both AREP A and AREP B. Don't be confused by thinking multiple personal representative information may be entered on one screen.

An AU may have multiple personal representatives. Complete the AREP for each personal representative that the A/R may have. This may also include CCSP and Hospice case managers. For example, a CCSP AU or Hospice AU may have personal representative information entered and also information regarding the name and address of the CCSP or Hospice Case Managers so that both will receive notices regarding the AU. However, if multiple representatives are entered, all will receive notices, including information regarding annual reviews.

KEY FIELDS

Rep Type: The Rep Type code used for ABD Medicaid AUs is either R1 or R2.

> **R1**: Only notices and review information will be sent to the AREP. Medicaid cards will be mailed to the A/R at the Residential or Mailing address.
> **R2**: Notices, review information and the Medicaid card will be sent to the AREP. Only one person should be coded as R2, if any.

Document:

- ✓ Authorized representative (responsible person) for ABD and why (if not included on NARR screen)

ASSISTANCE STATUS
STAT

```
INTERVIEW                  ASSISTANCE STATUS - STAT                  STAT    A
  Month 11 06                     0097   10 30 06                       01

 AU ID 106514343  Prog MA  Prog Type A  Prev ABD Type     Med COA S03   Claim N
    CO 049    LO 049    Load ID 1065    Conversion Date

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty----  Appeal
 Stat    Reasons      Date     Date     Date     Date    Type  End Date    Ind
  P                  103006   103006
 ---------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date    Date   Date    T   Date
 HERBER BLA   SE ?         ?    P 103006      103006
 SUSAN  BLA   SP ?         ?    P 103006      103006
 MARY   BLA   OR ?         ?    P 103006      103006


  Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                             20-rmen       22-alau(arch)      23-alau(curr)
```

INFORMATION

The STAT Screen is an AU level screen which displays information regarding the status of the case. Each AU will have a separate STAT Screen.

KEY FIELDS

AU Stat: Indicates a code for the current status of the AU.

P = pending M = spenddown
D = denied H = closed historically
C = closed

AU Status Reasons: Enter a numeric code from 500 – 579 to manually close or deny an AU. If the system has denied or closed the AU, the code will be a numeric code other than a 500 level code. Do not use code 570 – Call your caseworker; effective 1/27/03 SUCCESS will not allow the entry of this code.

Rel: The relationship code describes each household member's relationship to the HOH. Those most commonly used for ABD Medicaid are described as follows:

SE = always used for HOH, usually the A/R
NS = a spouse to the HOH and no children live in the household
SP = a spouse to the HOH and children live in the household
CH = a child of the HOH
FM = a parent to the HOH (may be used for parents of Katie Becket /Deeming Waiver A/R, if the child is entered as HOH)

Finl Resp: The Financial Responsibility code determines how the resources and income of this household member will be counted in the AU's budget. It is crucial that it is entered correctly. Codes will be listed in the most commonly used order for ABD Medicaid. Also refer to the SUCCESS User Manual, pages 1.2-10 and 11.

PN	A/R who is applying for some form of Medicaid. Don't use if the individual does not intend to receive any benefits. Use whenever a husband and wife are applying for Medicaid under the same COA (except for NH or CCSP). Use only at application.
RE	Individual is a Medicaid recipient. If the AU status is A but the A/R is not coded as an RE, that individual is not eligible to receive Medicaid. Case managers may not assign a financial responsibility code of RE. The system does this automatically when the AU is approved for any eligible individual coded initially as PN.
NA	Use for all ineligible spouses. Also use for a community spouse for all NH and CCSP AUs, even if the community spouse is receiving Medicaid or QMB at home. This code allows diversion to the spouse and the spousal impoverishment resource limit. If the community spouse is receiving CCSP, use NM for the spouse in the NH case.
AS	Use when two spouses are both receiving Medicaid under a different COA and a couple budget is needed for one of the COAs rather than a deeming budget.
LS	Use only when both the husband and wife are receiving CCSP or both are receiving NH Medicaid. They will have separate cases. In one case, the husband will be coded as PN and the wife will be coded as LS, and vice versa in the other case.
NM	Use when the individual has no financial responsibility in the AU's budget. For example, code an ineligible child as a NM.
NI	Use for an ineligible non-legal spouse.

IF Program Type = Medicaid ABD	THEN
Client Citizenship code = C Client Citizenship Verification code is either FB, HC, SP, CR, PR, SR, OG or UA	Client Finl Resp = “NA” ‘Client Reason’ “230”
Client Citizenship code = C Client Citizenship Verification code is either BC, CP, PS, CN, TR, SM, NR, AD, GM, DR, FY, AF or GC Orig/Cert = No	Client Finl Resp = “NA” ‘Client Reason’ “230”
Client Citizenship code = C ID = UA or NV	Client Finl Resp = “NA” ‘Client Reason’ = “230” ‘Client Status’ = “Active”

Stat: A code is assigned by the system displaying the current status of each individual HH member. These client codes include:

P = pending A = active
D = denied M = spenddown
C = closed

Rsn: Closure/Denial reason codes from 500 – 579 may be entered in this field to delete an individual HH member from the AU, but not close the entire AU. **NOTE: Reason Code 570 - Call your Caseworker** cannot be used. If the system has closed/denied the HH member a system generated code will appear in this field.

WORKER ENTERED AU / CLIENT LEVEL REASON CODES

The following are codes workers are allowed to enter on the STAT screen to deny an AU or a client:

500 Reside Community Boarding House
501 Reside Authorized Institution
502 Child Member Other TANF Case
503 Child Member SSI Assist Group
504 No Child Under Age 18
505 Disqualified Fail Provide SSN
506 Household Out of Project Area
507 Do Not Meet Alien Elig Requirement
508 Do Not Meet Student Elig Requirement
509 Resources Exceed Allowed Amount
510 Income Exceeds Max Amount
511 Citizenship
512 Residence
513 Not Within Degree of Relationship
514 Child No Longer Deprived
515 HH Participated Other Project Area
516 Failed to Apply for Potential Income
517 No Longer in FC Facility
518 Not Eligible Med Needy MAO
519 Employment Hours Exceed Max AF-UP
520 Program End Due to Federal Law Change
521 Moved Out of County (FS Only)
522 Approved for SSI
523 Client in Nursing Home
549 Voluntary Withdraw One Program
550 Voluntary Withdraw All Programs
551 Whereabouts Unknown
552 Failed to Provide Info to Determine Eligibility
553 AU Requested Closure of One Program
554 You Have Moved
555 Application Opened in Error
556 Not Cooperating with QC
557 AU Requested Closure of All Programs
558 AU Closed to Approve TANF Cash
559 Client Discontinued Name Clearance
560 Ineligible – SSI Pending
562 Financially Eligible for SSI
563 Failed to Sign Citizen Declaration
564 DA/HOH Failed to Comply with E&T
566 Did Not Cooperate with Eligibility Process
567 Drug/Alcohol Lost Certification
569 Placed in Foster Care
570 Other – Call Your Caseworker (not available for use after 01/03)
571 ABAWD Ineligible
572 Failed/Refused to Sign a PRP
573 TANF – Material Violation, Second Sanction
574 Ineligible - Employed
575 Ineligible - Married
577 Missed Application Deadline
578 Approved in Other Assistance Program
579 Received Benefits for the Same Month in Other County.
*598 Case Closed at Conversation – This is a 500 level reason code but is not worker returned. It is used only on cases converted from PARIS to SUCCESS.

DOCUMENT

- ✓ Name, age, relationship of anyone in the home other than the recipient and spouse
- ✓ Financial responsibilities
- ✓ Denials/closures codes entered by EW
- ✓ Changes in AU (additions and deletion of AU members)
- ✓ Circumstances and outcome of completing a CMD
- ✓ Dual eligibility for more than one COA
- ✓ Retroactive months requested (list) and determination for each of the months. AU ID number used for prior months, if different
- ✓ If A/R over CAP, document if QIT is in place and effective date.

TILDE ON STAT

```
XSGDWH##########################UHPDUNV#0#UHPD##########################UHPD#######
#######################################################################34########
###------------------------------#PHGLFDLG#VWDW#------------------------------###
###4324;2533:#35=44#SP#LPD#ZRUNHU/#::3E/#45<7/#WXUQHU/#888088808888#######
###OLVW#RWKHU###QDPH##################UHODW########DJH######ILQ#UHV#~\2Q¢########
###KK#PHPEHUV###=bbbbbbbbbbbbbbbbbb###=bbbbbbbbb###=bbbbb###=bbbbbbbb############
###QRW##LQFO#######=bbbbbbbbbbbbbbbbb###=bbbbbbbbb###=bbbbb###=bbbbbbbb############
###LQ#WKH#DX#######=bbbbbbbbbbbbbbbbb###=bbbbbbbbb###=bbbbb###=bbbbbbbb############
###LQHOLJLEOH2SHQDOL]HG#DX#PHPEHUB#\2Q#+#,#LI#\HV/#H[SODLQ=bbbbbbbbbbbbbbbb######
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###H[SODLQ#VWHS#SDUHQW#VLWXDWLRQ=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###WUDFH#UHODWLRQVKLSV#DQG#GRFXPHQW#ILQDQFLDO#UHVSRQVLELOLW\=####################
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###OLP#HOLJLEOHB#\2Q#+#,#LI#QR/#H[SODLQ=DSSO\LQJ#IRU#QKbbbbbbbbbbbbbbbbbbb######
###FPG/#DV#QHHGHG=##
###GXDO#HOLJ#DX#PHPEHU+V,2FRDB#H[SODLQ=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###6PS#FRYHUDJH#UTVWG1B#\2Q+Q,#LI#\HV/#PR1#DQG#GHWHUPLQDWLRQ#IRU#HD1=bbbbbb######
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###FURVV#UHI#DX&V#IRU#6PS#DQG#RQJRLQJ=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###H[SODLQ#XVH#RI#833#GHQLDO#FRGH=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
#######################################################################Pruh####
#PHVVDJH#########################################################################
###############################################################################
```

Note:

At application or review it <u>is</u> <u>never</u> <u>acceptable</u> to document:
"client states no change" or "client states no change in AU composition"
"Best Practice": Document any referrals done on closed/denied cases.

CLIENT DEMOGRAPHIC 1
DEM1

```
INTERVIEW                 CLIENT DEMOGRAPHIC 1 - DEM1                DEM1 01
  Month 11 06                     0097   10 30 06

 Client Name HERBERT        BLACK                Suf       Client ID 106594364

 Alt   SSA/SSN   SSN Appl      SSN1     V   More        DOB      V Sex Race Eth
 Name  Appl For    Date                     SSNs    (MM DD YYYY)
                           015 01 1065  CA           03 09 1927  BC  M   W   N


 GA   Marital   Living   RSM  Min Par  Boarder   Amt Paid -- Family Planning --
 Res  Status    Arrngmt Ad/Ch   /LA    Num Meals for Meals  Referral     Date
  Y     ?         ?


  Concurr   SSI   Depriv  V  Prenatal Care   ---------- Pregnant ---------  FTC
 Out of St  Recip            Ind  Good Cse   Term/Due  Term/Due  V  Num V  Code
 CA  FS MA                                    Code      Date        Exp
 N   N  N    ?


 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
               15-lett                       16-crs            23-alau
```

INFORMATION

The DEM1 screen is a client level screen that captures specific demographic information regarding each household member. Much of the demographic information is not required if the individual is not coded with a financial responsibility code of PN.

KEY FIELDS

SSA/SSN Appl For: Code representing the reason why the individual has not provided a social security number. If the A/R is an undocumented alien, enter either G or N as the code. Use of R for refusal will result in denial of benefits for the individual.

GA Res: A Georgia residency code of N will result in denial of benefits for the individual.

Marital Status: This code is for documentation purposes only and has no impact on the eligibility of the AU.

DEM1 screen (continued)

Living Arrngmt: The living arrangement code is important for certain LA-D COAs. Usually only AH, NH, or HO are used from all the codes provided.

AH = Use whenever the individual resides at home, even if it is the home of another (LA-B), CCSP or other waivered COA.
NH = Use for NH residents or Hospice in the NH COA.
HO = Use for hospital residents only.
CH = Children's home implies an orphanage or similar institution.

SSI Recip: Use of this code is primarily important for Katie Beckett (Deeming Waiver) COA. If a code of N is used in this instance with no income for the Katie Beckett A/R, the AU will deny as potentially eligible for SSI. Use a code of I for Katie Beckett A/Rs.

C = Use for all public law COA.
I = Use whenever the A/R is ineligible for SSI and income/resources in the AU could cause the AU to deny incorrectly. Use for Katie Beckett A/Rs.
N = Use in most instances when the individual has never applied for or received SSI.
R = Use when the individual is a current recipient of SSI. Use of this code will prevent approval of some COAs. The exceptions are QMB and NH.

NOTE: To change an individual's name, SSN, date of birth, sex, race or ethnic information, access CRS by pressing PF16. This information can not be keyed directly onto the DEM1 screen.

Document:

- ✓ Previous Marriages
- ✓ SSI ineligibility
- ✓ Any unusual circumstances about Georgia Residency
- ✓ Reason for the Living Arrangement code entered; at reviews document that A/R remains in same LA or why it has changed

CLIENT DEMOGRAPHIC 2
DEM2

```
INTERVIEW                 CLIENT DEMOGRAPHIC 2 - DEM2            DEM2 01
 Month 11 06                     0097   10 30 06

 Client Name HERBERT        BLACK                 Client ID 106594364

 Citiz V  Orig ID Student V  High Grade V Striker ---Immunization -  Law -Health Chk -
          Cert    Stat       Completed    Stat      Curr GCse Due Dt  Brkr Ref   Date
   ?                                  N

TPL  TPL   V  ------ Medicare -----    ------  Disability / Incapacity ------
Coop     Entitlmnt   Claim Num    Disab   Approval Begin Date  End Date
                                   Type   Source   (MM YYYY)   (MM YYYY)
  N    ?          ?

Joint  Vet   Military    Death   AFDC Cap Parent ------ AFDC Cap Child ----
SSI/FS Stat  Serv Num    Date     Ctr  End Date  Parnt ID Rcv Mo Cncpt GCse
  N     ?

 Non-Custodial Parent?     V


 Message 0013
 0215 NO DATA AVAILABLE FOR DISPLAY
               15-lett                                   22-tpl 23-alau
```

INFORMATION

The DEM2 screen is a client level screen that continues to capture specific demographic information regarding each household member.

KEY FIELDS

Citiz: For U.S. citizens, use a code of C. For undocumented aliens or for documented aliens who do not meet the 5 year rule, the citizenship field must be coded as U in order to process EMA application. Using a code such as D or X will result in the A/R receiving full Medicaid, since SUCCESS programming does not recognize the date of entry field on the ALAS screen.

V: See information on pages 18 – 19.

Orig Cert: Original/Certified: These fields are mandatory and will require a value to be entered beginning with the system benefit month of 03/2008 for the Medicaid program. Entry of the new fields is not allowed for any benefit month prior to 03/2008.

Y = Yes

N = No

Coding this field NO will deny the Medicaid AU.

ID: Identity is a mandatory field for Medicaid. If ID is not verified, the client will not be included in the benefit. Although ID is not required for ABD ARs whose citizenship is verified through receipt of Medicare or receipt of RSDI disability, the field must be coded. "GI" may be used in these situations.

Identity (ID) Field	
DL	State Driver's License
TR	American Indian or Tribal Documents
MI	Military ID
GI	Government issued ID
SI	School Identification
PS	US Passport issued with limitations
SR	School Record
HR	Hospital Record
DC	Daycare or Nursery school record
AF	Affidavit signed by parent
NV	Not verified – Refused
UA	Unable to verify

TPL Coop: If the A/R agrees to cooperate with TPL requirements enter a C. A code of N indicates that the A/R refuses to cooperate, and the AU will be denied or closed.

Medicare Entitlmnt: In order for any Q Track COA to be approved, code this field as Y. In order for an S05/S06 [Widow(er) COA] to be approved, this field must be coded as N.
Medicare Claim Num: This field is required if the Medicare Entitlement code of Y is entered. It is optional if a code of N is entered. The claim number must be entered in a valid claim number format with no dashes or spaces. Example: 123456789C1.

Disability/Incapacity: These are required fields for any ABD Medicaid A/R who is under the age of 65.

Disab Type: Access these codes by pressing PF1.
NOTE: Disability Type Code X-Not Disabled can only be used with ABD COAs. If the Disab Type is entered as X, the system will not require an entry in the Approval Source, Begin Date, or End Date fields. The case will close as not meeting the aged, blind or disabled criteria.

Approval Source: The most commonly used codes for ABD Medicaid are DA for a DAS disability approval, RS for prima facie disability from SSA, or SM for SMEU disability approval. If DP (DAS pending) or MP (SMEU pending) is left on the DEM2 screen when the case is finalized, the case will be denied as having no eligible members.

Begin Date: Enter the month and four digit year that the A/R was ruled disabled.

End Date: Normally a disability end date is not entered unless the A/R is ruled no longer disabled. If an end date is entered, the case will close or deny effective the month/year of the end date.

Death Date: Enter the month, day and two digit year that a household member dies. If the individual is an LA-D A/R, also enter the death date on the INST screen as a discharge date and payment termination date.

Document:

- ✓ Details of disability/incapacity codes
- ✓ Details, resolution of Death Match interface
- ✓ Form DMA-327 sent to DCH upon death of recipient in L01 or W01
- ✓ Citizenship verification or Alien status if A/R is not a citizen.
  - The type of evidence used to verify citizenship should be documented.
  - If receipt of Medicare or SSI is used to verify citizenship, this should be clearly documented.
  - If prior receipt of SSI is being used to verify, the dates of receipt of SSI and method of verification should be included as well.
  - If citizenship is not verified by a document from the first tier, identity needs to be documented, and the type of evidence used to verify identity should be documented. Document that original documents were viewed for citizenship and identity. This should be done behind the DEM2 screen for each AU member.
- ✓ Declaration of Citizenship is in record. Declaration of Citizenship can be addressed on DEM2 01 for ALL AU members.
- ✓ Availability of TPL (TPL1 screen should <u>not</u> be used)
- ✓ Form signed for assignment of TPL.
- ✓ Details of non-cooperation for TPL, if applicable
- ✓ Document date form 285 sent to DMA including trusts and QITs, if applicable
- ✓ HIPP referral, if applicable

TILDE ON DEM2

```
XSGDWH#####################################UHPDUNV#Ù#UHPD#########################UHPD########
#######################################################################################
34########
###-----------------#KHDOWK#LQVXUDQFH2FLWL]HQVKLS2LGHQWLW\#-----------------###
###4324;2533:#35=48#SP#LPD#ZRUNHU/#::3E/#45<7/#WXUQHU/#888088808888#######
###GRHV#D2U#KDYH#KHDOWK#LQVXUDQFH#RU#RWKHU#WSO#~WUXVW/H1J1¢B##\2Q#+#,############
###LI#\HV/#GDWH#IRUP#5;8#VHQW#WR#GPD=bbbbbbbbbbbbbbbbb##########################
###DVVLJQPHQW#RI#WSO#ULJKW#FRPSOHWHGB##\2Q#+##,#
###VLJQHG#IRUP#GPD#5;8#LQ#WKH#UHFRUGB##\2Q#+##,##
#######################################################################
###FXVWRPHU#ZDV#LQIRUPHG#DERXW#KHDOWK#FKHFN#E\##################################
###IDFH#WR#IDFH+#,#WHOHSKRQH+#,#PDLOHG#EURFKXUH+#,##############################
#######################################################################
###FLWL]HQVKLS#YHULILHG#E\=#bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###LGHQWLW\#YHULILHG#E\=#######################################################
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######
###GHFODUDWLRQ#RI#FLWL]HQVKLS#LQ#UHFRUG#GDWHG=#
#
###IV#RQO\#Ù#FLWL]HQVKLS#JRRG#FDXVH#ZDLYHU#JUDQWHG#GXH#WR=bbbbbbbbbbbbbbbbb######
###=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb######

#######################################################################
```

Citizenship Verification (Effective 03/2008)

The following is a list of the types of verification and the corresponding valid values that should be used to code citizenship and identity. These are the valid values that are acceptable for Medicaid based on current acceptable verification documents. Since Medicaid has the most stringent verification requirements, these valid values are acceptable and should be used for all eligibility programs.

Citizenship Verification Valid Values (All Programs)	
PS (US Passport)	Current or expired U.S. Passport (not limited passports)
CN (Certificate of Naturalization)	Certificate of Naturalization (N-550 or N-570) Certificate of Citizenship (N-560 or N-561)
TR (Tribal/American Indian Record)	American Indian card(I-872) issued by the Dept. of homeland Security with the classification code “KIC” Certificate of Indian blood or other U.S. American Indian/Alaska native tribal document.
SM (SSI/Medicare)	Persons currently receiving SSI. Persons receiving Social Security Disability or Medicare.
GM (Government/Civil Service Record)	A U.S. birth certificate or data match with state vital records. U.S. public birth record showing birth in one of the U.S. states, District of Columbia, American Samoa, Swain’s Island, Puerto Rico if born on of after 1/13/1941, Virgin Islands if born on or after 1/17/1917, Northern Mariana islands if born on or after 11/4/1986 or Guam if born on or after 4/10/1899. Certification of Report of Birth (DS-1350) issued by the Dept. of State. United States Citizen Identification card (I-197 or I-179) Official Military record showing U.S. place of birth. Early school record showing a U.S. place of birth. The school record must show the name of the child, date of admission to the school, the date of birth, and names and places of birth of the applicant’s parents. Federal or State census record showing U.S. citizenship or U.S. place of birth.
NR (Naturalization Record)	Consular Report of Birth Abroad of a U.S. citizen (FS-240) or Certification of Birth Abroad (FS-545)

	Northern Mariana identification card (I-873) or Collective naturalization for those who lived in the Northern Mariana Islands.
AD (Adoption Decree)	Final Adoption Decree
DR (Statement signed by Physician or Midwife)	Medical (clinic, doctor or hospital) record indicating a U.S. place of birth and was created at least 5 years before the initial application date.
FY (Documents created 5 years before application for Medicaid shows place of birth)	Extract of hospital record on hospital letterhead indicating a U.S. place of birth established at the time of the person's birth and was created at least 5 years before the initial application date (for children under 16, the document must have been created near the time of birth or 5 years before the date of application) Life or health insurance record showing a U.S. place of birth and was created at least 5 years before the initial application date. Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization (entries in a family bible are not considered religious records) Institutional admission papers from a nursing home, skilled nursing care facility or other institution indicating a U.S. place of birth and was created at least 5 years before the initial application date. Other document that shows a U.S. place of birth and that was created at least 5 years before the application for Medicaid. The include Seneca Tribal census report, Bureau of Indian Affairs tribal census records of the Navajo Indians, a U.S. vital statistics official notification of birth registration.
AF (Affidavit)	Used as last resort. Please refer to 2215-3 of the Medicaid manual for requirements.
GC (Good Cause)	Code may be used for applications and reviews completed in the Food Stamp and TANF Programs. Good Cause cannot be granted at application for Medicaid; it is only valid for ongoing cases in Medicaid.

ALIENS AND STUDENTS
ALAS

```
INTERVIEW                 ALIENS AND STUDENTS – ALAS                 ALAS 01
  Month 11 06                     A137   10 30 96

 Client Name MARIA          LOPEZ                 Client ID 106562237
                                              Permanent
Citiz  Elig V   Doc  Spons  Country   Entry Date  INS      -- Emergency Med ---
       Stat     Type Alien  of Origin (MM YYYY)  Number   Ind  Beg Dt   End Dt
  U                            ?

 INS Auth To Work     Refugee Resettlement Agency


 Student Educ      School Name       Dep Care   Grad Date    Meals    20 Hr/Wk
 Status  Level                       Respon      (MM YY)    Provided  Work Rqmt


 School Attend Cd

 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY “?”
                 15-lett
```

INFORMATION

The ALAS screen is a conditional client level screen which only appears if data is entered on the DEM2 screen indicating that the individual is an alien or a student. The citizenship field and student status fields are pre-populated from data entered on DEM2.

KEY FIELDS

Citiz: If the A/R is an alien, the citizenship code determines what is required on this screen and the outcome of the case. If the citizenship code needs to be changed, return to DEM2.

C: This screen will only appear for a citizen if the A/R is coded as a student.
D or X: D refers to Documented Aliens, whereas X refers to Permanent Residents. The Elig Stat, Spons Alien, Country of Origin and Permanent Entry Date are required fields. Eligibility for ABD and FS is permitted with either of these citizenship codes. **NOTE: a documented alien who does not meet the 5 year rule should be coded as U if eligible for EMA.**

E, P or R: Entrants or Parolees who entered after 8/22/96 must be coded as either E or P. R is reserved for Refugees. The Elig Stat, County of Origin and Permanent Entry Date are required fields. Eligibility for ABD and FS is permitted with any of these citizenship codes.
U: For an Undocumented Alien, the Country of Origin is a required field. FS will automatically deny the application. ABD Ars will only be eligible for month(s) in which EMA dates are entered for the same benefit month.

Elig Stat: Enter the appropriate code for the program type(s) for which the A/R is applying. Be sure to select a code which will allow eligibility for the program type for which you wish the A/R to be eligible.

Spon Alien: Enter a Y or N to indicate if the individual is a sponsored alien. This will have no affect on eligibility for FS or ABD.

Country of Origin: Enter the appropriate code to reflect the individual's home country. If the country is not one of the codes on the list, select OT and document the name of the country.

Permanent Entry Date: Enter the month and four digit year that the individual was granted permanent entry into the U.S. This is a required field for citizen status of D, E, P, R, or X.

INS Number: This is an optional field for entry of the individual's Immigration and Naturalization Service number.

Emergency Med: The fields under Emergency Med should only be used in situations where the individual is potentially eligible for EMA.

NOTE: Entry of EMA service dates are only allowed using the P or R functions. EMA service dates cannot be entered during the O function. EMA service dates will display in blue and cannot be changed after the nightly batch has processed for the date of entry.

Ind: Enter a Y to indicate potential EMA eligibility. Failure to enter a Y will result in denial/closure of the affected client.
Beg Dt: Enter the two digit month, day and year in which a medical statement or Form 526 indicates that medical services were provided.
End Dt: Enter the two digit month, day and year in which the medical statement or Form 526 indicates that medical services were provided. The end date should never be more than 30 days from the begin date. For subsequent emergency services received, applicants will need to complete a new application AND provide a medical statement or Form 526 indicating the emergency services received.

NOTE:

- A maximum of three date spans can be entered per benefit month. EMA service dates must be entered in the first available date fields. An online edit message will appear on the ALAS screen if an attempt is made to enter EMA service dates on a row when the EMA service date fields above are not entered.
- Date spans for historical or current benefit months must fall within the first and last day of that specific month.
- Prior month date spans must be completed in the prior month process.

INS Auth to Work: Although the screen allows a Y or N response in this field, it creates a Hard Error at processing. **Do not use this field**.

Refugee Resettlement Agency: This is a free form area in which the case manager may enter the name of the Refugee Resettlement Agency.

Student Status: If the individual is a student, enter the appropriate code to reflect if the student is full time, half time, less than half time or not a student.

Educ Level: Enter the appropriate code that best represents the type of training or schooling the individual is receiving.

School Name: This field allows free form entry of the name of the institution where the individual is receiving training or schooling. It is a required field if the Student Status field is completed.

Dep Care Respon: Enter the appropriate code for the reason why the individual is paying child care expenses for his/her child.

Grad Date: Enter the two digit month and year in which school/training is expected to be completed.

Meals Provided: Enter a Y or N to indicate if the school provides a majority of the individual's meals. This field only applies to FS AUs.

20 HR/Wk Work Rqmt: Enter a Y or N to indicate if the FS individual works at least 20 hours per week or if the FS individual is participating in an activity that substitutes for the 20 hour per week requirement. Consult the policy manual.

School Attend Cd: Enter the appropriate code if the individual has good cause for not attending school, or if the individual satisfactorily or unsatisfactorily meets this requirement.

Document:

- ✓ The 40 qualifying quarters for aliens
- ✓ Details of form 526 for EMA

INSTITUTION
INST

```
INTERVIEW                        INSTITUTION – INST                      INST 01
 Month 11 06                     A137   10 15 06                        01

 Client Name THOMAS         HING                  Client ID 106510738


 D Inst   Prov    Admission Discharge   NH     LOC  V  Payment   -- Payment --
   Type    ID       Date      Date    Perdiem  Auth    Auth Date Term DT   Rsn


 Diversion  Dep/Family Divert  Pat Liab Inc Incurr Med Exp Inc   - Medicare -
 Amount  V  Num Gross Inc V      Amount V    Amount    V   Prot  Prem Amt  V


   Extra    - HCB Waiver -    Deem Wvr  DMA Spcl  Length/  V   ICD-9  Recon
 Hardship  Type Slot Date    Cost Eff  Wvr Code  Stay Met             Ind
                                                                       N
                                                             More Institutions
 Message

          15-lett 16-pmen                                          24-del
```

INFORMATION

The INST screen is a client level screen used to record information regarding LA-D COAs. The information entered here replaces the manual DMA-59 and is transmitted via an interface to DMA. It is important that data is entered timely, accurately and for all affected benefit months in order for the Nursing Home or other entities to be correctly and timely reimbursed.

KEY FIELDS

Inst Type: Select the appropriate code for the LA-D COA as follows:

HO = Use for Hospital COA.
HP = Use for Hospice Care at home or in a nursing home.
NH = Use for Nursing Home COA.
WV = Use for all Waivered COAs except Hospice.

Prov ID: A provider ID number is only entered for NH COA. This number may be found on the DMA-59 or may be found by pressing PF16 to access the provider menu and entering the name of the nursing home.

INST Screen (continued)

NH Perdiem: It is only necessary to enter a NH per diem amount for NH COA. This dollar amount is provided by the NH upon inquiry about their private pay daily rate (per diem). If no amount is entered in this field a warning message will be displayed. Press PF4 to proceed to the next screen.

LOC Auth: The appropriate level of care is entered according to the COA and LOC as stated on the DMA-59 or Communicator.

- C = Use if the COA is CCSP.
- H = Use for Hospital or Hospice Care COA.
- I = Use for an approved Intermediate LOC.
- M = Use for an approved Mentally Retarded Intermediate LOC on a DMA-6.
- N = Use when an LOC has been denied. This will cause denial of the LA-D COA.
- S = Use for an approved Skilled LOC on a DMA-59.

LOC Auth V: Verification of LOC codes are as follows:

- CC = Use for the CCSP LOC and Placement Instrument.
- CF = Use for the Hospice Care Communicator Form (HCC).
- DM = Use for any COA which requires a DMA-6
- HC = Use for any verification of hospital LOC. Document how this was determined.
- CS = Should not be used to verify LOC.
- OT = Use only with sufficient documentation.

Payment Auth Date: Enter the month, day and two-digit year in which Medicaid payment should begin. This date is used by DMA to determine when to begin paying NH or Waivered agencies for their services. For NH COA, this date should be the admission date located on the DMA-59. For other waivered COAs, this date is the date the first waivered service is received.

Payment Term Date: Enter the month, day and two-digit year in which Medicaid payment should stop. This date should be the day following the Certified Through date on the CCSP LOC Form and the day following the End Date on the DMA-6. For NH COA, this date should always be 02/02/20. DMA will stop paying these facilities beginning with the date entered as the Term Date. It is imperative that these dates are changed timely as new LOC/LOS information is received. If an A/R dies or is discharged from the facility or waivered program, enter the actual date of death or discharge as the Term date.

INST Screen (continued)

Payment Rsn: Enter the appropriate reason code.

- L = Use for most limited stays.
- G = Use when the A/R has died.
- A = Use when the A/R goes home with an approved health plan, for example to CCSP.
- B = Use when the A/R discharges to the hospital.
- C = Use when the A/R discharges to a nursing home/swing bed.
- D = Use when no other code seems to fit. Document why this code was used.
- E = Use when the A/R is no longer eligible for a vendor payment to be made on their behalf. The AU may be closing, but possibly not as in the case of a transfer penalty.
- H = Use when the A/R discharges to home and no health plan.
- M = Use when the A/R's nursing home stay is paid by Medicare.

Diversion Amount: Enter a dollar amount **if the amount diverted to the spouse should be different from what the system computes**. Otherwise this field may be left blank. Always document the reason for using this field.

Pat Liab Amount: **This field should only be used if a patient liability/cost share amount needs to be different from what the system computes.** For example when the A/R's computed patient liability exceeds the Medicaid monthly billing rate. Take into consideration automatic deductions such as the personal needs allowance. Always document the reason for using this field.

Incurr Med Exp Amount: Enter the total monthly amount of any incurred medical expenses that should be deducted from the patient liability/cost share computation.

Inc Prot: Enter the appropriate code for income protection in the month of admission or discharge as A to protect all, H for half. If no income is protected, leave the field blank. The system knows to only use this field in the month of admission or discharge. If the code remains in other months in which income should not be protected, it will not be deducted from the patient liability/cost share computation.

Medicare Prem Amt: Enter the amount of the Medicare premium which should be deducted from the patient liability. Effective the second month following the month of approval, the Medicare premium will be automatically removed by SUCCESS from the PL/CS budget. The deduction will also be removed from the INST screen for the effective month of removal. If the AR is being approved for a Q-track Medicaid and an LA-D type, the Medicare premium may not be deducted at all or may need to be removed manually depending on when the Q type will begin.

INST Screen (continued)

HCB Waiver: These fields are required for all W01 COA.

Type: Enter the appropriate code depending on the A/R's Waivered COA.

C = Use for CCSP.
D = Use for Katie Beckett (Deeming Waiver) COA.
H = Use for Hospice Care at home or in the nursing home.
I = Use for ICWP COA.
M = Use for MRWP.

Slot Date: Enter the month, day and two digit year that the A/R was placed in a slot according to the Communicator.

Length/Stay Met: These fields are required for all LA-D COAs. The first field code choices are Y or N. The N code will result in denial/closure of the AU. The second field is for the LOS verification code. Choose an appropriate code as follows:

CF = Use when the verification is from any communicator form.
CS = This is not a valid source of verification.
HC = Use any acceptable verification from hospital for L02 COA, such as telephone call or discharge summary.
NH = Use any acceptable verification from nursing home for L01 COA, such as DMA-59 or telephone call.
OT = Use when none of the other codes apply. Always document when this code is used.

ICD-9: Enter the number of the diagnostic code which appears on the DMA-59. This is a required field for NH AUs.

Document:

- ✓ Level of Care: changes, date packet sent to GMCF & returned, reason if LOC is denied
- ✓ Limited Stay extensions
- ✓ Changes in institutional status (such as a change to Hospice COA)
- ✓ Residence prior to admission and upon discharge for protection of income determinations
- ✓ IMEs and verification source
- ✓ Diversion, if applicable
- ✓ Differences between admission date and payment date
- ✓ Reason for reconciliation and months affected
- ✓ Any periods not covered by DMA-6, Communicator or other LOC instrument
- ✓ Reason for use of Pat Liab Amount field; explain how the amount entered was obtained
- ✓ Hospital stays and how verified
- ✓ Explain reason for protection of income

TILDE FOR INST

```
-------------------------------#LQVWLWXWLRQ#-------------------------------##
#4324;2533:#36=38#SP#LPD#ZRUNHU/#::3E/#45<7/#WXUQHU/#888088808888#
#UHDVRQ#IRU#SURWHFWLRQ=#bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb#
bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb#
#W\SH#RI#LPH=#bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb############################
#OLPLWHG#VWD\#H[WHQVLRQ0#QHZ#GPD9#UHFHLYHG=bbbbbbbbbbbbbbb~GDWH¢1#############
#QHZ#OHYHO#RI#FDUHB##\2Q#+#,##################################################
#JDS#LQ#SD\PHQW#\2Q#+#,1##LI#\HV/#H[SODLQ=#bbbbbbbbbbbbbbbbbbbbbbbbbbbbbb#####
#=bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb#####
```

PATIENT LIABILITY/COST SHARE RECONCILIATION RECO

```
UPDATE       PATIENT LIABILITY/COST SHARE RECONCILIATION – RECO      RECO
 Month 11 06                     5601   10 15 06                       01

 HOH Name THOMAS         HING                        AU ID 106504820


 ------ AU Patient Lib/Cost Share Inc -------       --------- IME -----------
 Del      Mo/Yr     Avg Amt        Actual Amt       Avg  Amt        Actual Amt
          09/06        1200                              50
          08/06        1200                              50
          07/06        1200                              50
                   __________      __________       __________      __________

 Totals                1600                             150

 Recon Amt

 Message

                 13-note  15-lett                                24-del
```

INFORMATION

The RECO screen is used to complete a patient liability/cost share reconciliation when the recipient's income and/or Incurred Medical Expenses have fluctuated in the past three months. Consult your policy manual for why reconciliation is necessary. The RECO screen may only be accessed in the current benefit month from the INST screen by pressing PF20. Complete the RECO screen by entering the actual total amounts of income and IME for each month as indicated. Refer to the SUCCESS Functions portion of this participant guide for the steps in completing a reconciliation. If the income or IME is a one time occurrence, simply enter the income in UINC/ERN1 and the IME on INST for the month in which the income/expense occurs.

RESOURCES 1
RES1

```
INTERVIEW                      RESOURCES 1 – RES1                      RES1 01
 Month 11 06                                                             01

 Client Name HERBERT        BLACK                 Client ID 106594364

 Do you have any of the following: cash, money loaned out, checking, savings,
 credit union, CD's, stocks, bonds, or secured notes?

 Del Type   Amount   V       Acct Num        Institution Name



 Do you have any of the following: life insurance, pre-paid burial contracts,
 real estate, or cemetery lots?

 Del Type Face Amt   Cash Amt V    Policy Num        Company Name
                                                                  More

 Message

                 15-lett                                        23-alau   24-del
```

INFORMATION

The three resource screens gather information pertaining to the resources owned by the individual identified by the client pointer in the upper right hand corner of the screen. The questions that appear on the RES1 screen are misleading. The top question does not include every resource that has a valid value available for this question. The bottom question states that it is for life insurance, pre-paid burial contracts, real estate and cemetery lots. In reality the only valid values available for the bottom question pertain to life insurance and burial contracts. Real estate valid values are on RES2 in the bottom question, and cemetery lots, burial plots and burial space valid values are found on RES3.

RES1 Screen

KEY FIELDS: First Question

Below is a listing of the Valid Values for Type of resource, whether an Institution Name is required, and how the resource is counted in FBR, Non-FBR and FS AUs. Acct Num is **not required** for any resource valid value.

NOTE: The Food Stamp Program's resource policy is the same as the TCOS resource criteria, which excludes non-liquid resources from the eligibility determination. If an AU is not categorically eligible, the liquid resources are included in the eligibility determination. Refer to FS Policy Manual Section 3210, Categorically Eligible Assistance Units and Section 3211, Expanded Categorical Eligibility, TANF Community Outreach Services, for policy regarding categorically eligible households.

VALID VALUE	INSTITUTION NAME	FBR	NON-FBR	FS
AA	Not required	Counts	Counts	Counts
AI	Not required	Disregards	Disregards	Disregards
BC	Required	Disregards	Disregards	Disregards
BD	Required	Counts	Counts	Counts
BF	Required	Disregards up to $1500, regardless of other burial resources	Disregards regardless of amount entered	Counts full amount
BR	Required	Disregards up to $1500, if no other burial expense items entered	Disregards	Counts full amount
CA	Not required	Counts	Counts	Counts
CD	Required	Counts	Counts	Counts
CH	Required	Counts	Counts	Counts
CU	Required	Counts	Counts	Counts
DI	Required	Counts	Disregards	Disregards
ET	Not required	Disregards	Disregards	Disregards
FS	Not required	Disregards	Disregards	Counts
IR	Required	Counts (shouldn't count for deemor)	Counts (shouldn't count for deemor unless spousal impoverishment)	Counts
KE	Required	Counts (shouldn't count for deemor)	Counts (shouldn't count for deemor unless spousal impoverishment)	Counts
LC	Not required	Counts	Counts	Counts
LN	Not required	Disregards	Disregards	Disregards
LR	Not required	Disregards	Disregards	Disregards
LS	Not required	Disregards	Disregards	Counts
PA	Required	Disregards	Disregards	Disregards
PE	Not required	Disregards	Disregards	Disregards
PF	Not required	Counts	Counts	Counts
PI	Not required	Counts	Disregards	Disregards
PN	Not required	Counts	Counts	Counts
PR	Required	Counts	Counts	Counts
SA	Required	Disregards	Disregards	Disregards
ST	Required	Counts	Counts	Counts
SV	Required	Counts	Counts	Counts
TA	Not required	Counts	Counts	Counts
TI	Not required	Disregards	Disregards	Disregards

KEY FIELDS: Second Question
The question at the bottom of the page only has two valid value options, despite the wording of the question. Both of the valid values pertain to life insurance and require entry of the Policy number and Company Name.

LI = FBR: Disregards the FV if the amount entered is less than or equal to $1500, regardless of the CV. If the FV exceeds $1500, the cash value is counted as a resource. No other burial expenses are disregarded if the life insurance meets the $1500 allowable burial expenses.

NON-FBR: Disregards the FV if the amount entered is less than or equal to $10,000, regardless of the CV. If the FV exceeds $10,000, the CV is counted as a resource. No other burial expenses are disregarded if the life insurance meets the $10,000 burial exclusion allowance.

FS: Disregards regardless of FV or CV.

LT = Disregards any amount entered for FBR, NON-FBR and FS. If the FV exceeds $10,000, the remainder is subject to Estate Recovery. No other burial expenses are disregarded if the life insurance meets the $10,000 burial exclusion allowance.

Document:
- ✓ Conversion or disposition of resources at review or interim change, including spousal impoverishment
- ✓ Explain any unusual activity involving resources and countable value if amount is not readily apparent
- ✓ Dates of letters, bank statements, etc. used as verification
- ✓ Potential inheritances
- ✓ Disposition of previously owned bank accounts or other resources, and potential jointly owned resources at review or interim change
- ✓ Burial fund exclusions (life insurance, burial contracts, burial funds)
- ✓ Explain financial instrument used to fund QIT
- ✓ For Promissory Notes, Loans and Property Agreements explain how the resource amount was calculated

RESOURCES 2
RES2

```
INTERVIEW                    RESOURCES 2 – RES2                      RES2 01
 Month 11 06                                                           01

 Client Name HERBERT        BLACK                 Client ID 106594364

 Do you have any of the following: truck, motorcycle, tractor, farm equipment,
 licensed/unlicensed vehicle(s), boat, camper, income producing vehicle?

 Del Type  Use       FMV    V  Encumb   V   Yr  Make  Mod  Lic Num Registration
        MA/AF FS

                      VIN

 Do you have any of the following: vacation home, real estate, or rental prop?

 Address                          City                  ST     Zip

 Del   Use    FMV    V     Encumb  V     Try     Annl Rate  V   Age Life
                                     to Sell    Ret Amt       Est Own


                                                                  More
 Message

          15-lett                                        23-alau   24-del
```

INFORMATION

The RES2 screen is a continuation of screens which collect information pertaining to the resources of the individual identified by the client pointer. The two questions on this screen specifically collect information on vehicles and real estate.

KEY FIELDS: First Question

Type: Enter the appropriate code for the type of vehicle owned. If a vehicle type code is entered, then the Use, FMV, YR, Make and Model fields are required.

NOTE: Effective 2/1/05, Food Stamp AUs are not required to report ownership of a vehicle and vehicle ownership is not required documentation in the case record or on SUCCESS. If the FS AU has a related case, TANF or Medicaid, and owns a vehicle that has to be included in the related case, complete the MA/TANF Use code field with the appropriate code and enter valid value IN for the FS Use field. The IN code will disregard the vehicle for FS purposes.

NOTE: The Food Stamp Program's resource policy is the same as the TCOS resource criteria, which excludes non-liquid resources from the eligibility determination. If an AU is not categorically eligible, the liquid resources are included in the eligibility determination. Refer to the FS Policy Manual Section 3210, Categorically Eligible Assistance Units and Section 3211, Expanded Categorical Eligibility, TANF Community Outreach Services, for policy regarding categorically eligible households.

RES2 Screen (continued)

The affect on the eligibility budget in ABD is reflected in the chart below:

VEHICLE TYPE	ABD
MV (Motor vehicle)	Disregards
RV (Recreational vehicle)	Counts
UV (Unlicensed vehicle)	Counts

NOTE: For ABD Medicaid the system disregards the FMV for all vehicles coded as MV. If there are FBR AUs with multiple vehicles where one vehicle needs to be counted, code the countable vehicle as RV or UV to have the system count the value of the vehicle in the eligibility determination process.

Use: The vehicle use field is for determining how the individual utilizes the identified vehicle. Regardless of the COA or use of the vehicle for ABD Medicaid, the resource will be counted if the Type is RV or UV. See the chart below for the affect on the eligibility budget.

VEHICLE USE	ABD
DA (Daily activities)	Counts
EM (Employment travel)	Counts
FV (Family/Primary vehicle)	Counts
HA (Handicapped use)	Counts
IN (Inaccessible)	Counts
IP (Income producing)	Counts
LD (Distance work travel)	Counts
MA (Medical transportation)	Counts
OT (Other)	Counts
PR (Living in vehicle)	Counts
TE (Work training use)	Counts
WF (Water & fuel transportation)	Counts

Encumb: Enter the amount of any encumbrances against the vehicle. This amount will be subtracted from the Fair Market Value.

Yr: Enter the two digit year of the vehicle.

Make: Enter the manufacturer's name of the vehicle such as Ford, Toyota, etc. Up to five characters may be entered.

RES2 Screen (continued)

Mod: Enter the model name of the vehicle, such as Civic, Corrolla, etc. Up to five characters may be entered.

Lic Num: Enter the license number of the vehicle. Up to seven characters may be entered. This is an optional field.

Registration: Enter the registration number of the vehicle. Up to twelve characters may be entered. This is an optional field.

VIN: Enter the vehicle identification number. Up to twenty characters may be entered. This is an optional field.

KEY FIELDS: Second Question

Address: Enter the street address of the realty property. Up to twenty-two characters may be entered

City: Enter the name of the city where the property is located. Up to fifteen characters may be entered.

ST: Enter the two letter abbreviation for the state where the property is located.

Zip: Enter the five digit zip code and four digit zip plus, if known.

RES2 Screen (continued)

Use: Enter the appropriate code for the use of the property. When certain codes are entered, other fields may be required. Refer to the chart below for the affect of the Use code on the eligibility determination process.

USE CODE	REQUIRED FIELDS	Try to Sell	FS	FBR	NON-FBR
HP (Homeplace)	FMV	NA	Disregards	Disregards	Disregards
IN (inaccessible)	FMV, Try to Sell	Y	Disregards	Disregards	Disregards
		N	Disregards	Disregards	Disregards
IP (Income producing)	FMV, Try to Sell	Y	Disregards	Disregards	Disregards
		N	Disregards	Disregards	Disregards
LE (Life Estate)	FMV, Try to Sell, Age Life Est Own	Y	Disregards	Disregards	Disregards
		N	Disregards	Counts	Disregards
NP (Non Business Income producing)	FMV, Try to Sell, Annl Rate Ret Amt	Y	Disregards	Disregards	Disregards
		N	Disregards	Counts	Disregards
RI (remainder interest)	FMV, Try to Sell, Age Life Est Own	Y	Disregards	Disregards	Disregards
		N	Disregards	Counts	Counts
RP (Other)	FMV, Try to Sell	Y	Disregards	Disregards	Disregards
		N	Counts	Counts	Counts

Encumb: Enter the amount of any encumbrances against the property. This amount will be deducted from the Fair Market Value.

Annl Rate Ret Amt: Enter the amount of the annual rate of return or the amount of income this property produces in a year. This field is only required for Non-Business Income producing property and has no impact on the eligibility budget. However, if the property is producing income, the income should be entered as earned or unearned income as appropriate.

Age Life Est Own: Enter the current age of the individual who owns the **life estate** interest in the real estate property, even if the A/R owns the remainder interest. The system will calculate the resource value based on the life estate interest individual's age and the FMV of the property.

Document:

- ✓ Good faith efforts to sell
- ✓ Bankruptcy
- ✓ Conversion or disposition of resources at review or interim change, including spousal impoverishment
- ✓ Vehicle use if use code is not self explanatory
- ✓ Joint ownership
- ✓ Liens
- ✓ Rebuttal process
- ✓ If more than one vehicle, vehicle excluded and reason
- ✓ Life estate
- ✓ Disposition of previously owned property
- ✓ All real property other than homeplace
- ✓ Completion of property search, if applicable to COA, results, and any discrepancies

RESOURCES 3
RES3

```
INTERVIEW                      RESOURCES 3 – RES3                      RES3 01
 Month 11 06                                                             01

 Client Name HERBERT        BLACK                 Client ID 106594364

 Do you have any of the following: safety deposit box, business holdings, non-
 home consumption produce, livestock, or other valuables?

               ----------------- Other Property ------------------

                Del  Type     FMV   V    Encumb  V   Annl Rate  V
                                                     Return

                                                                        More
 Message

           15-lett                                                     24-del
```

INFORMATION

This screen is a continuation of the resources owned by the individual indicated by the client pointer. The question, as worded, does not address every resource for which there is a valid value listed.

KEY FIELDS

Type: Enter the appropriate valid value for the resource owned by the individual. The affect it has on the eligibility of the AU is indicated in the following chart.

NOTE: The Food Stamp Program's resource policy is the same as the TCOS resource criteria, which excludes non-liquid resources from the eligibility determination. If an AU is not categorically eligible, the liquid resources are included in the eligibility determination. Refer to FS Policy Manual Section 3210, Categorically Eligible Assistance Units and Section 3211, Expanded Categorical Eligibility, TANF Community Outreach Services, for policy regarding categorically eligible households.

RES3 Screen (continued)

RESOURCE TYPE	FS	FBR	NON-FBR
AO	Disregards	Disregards	Disregards
BI	Disregards	Disregards	Disregards
BN	Counts	Disregards	Disregards
BO	Counts	Counts	Disregards
BP	Disregards	Disregards	Disregards
BS	Disregards	Counts	Counts
DA	Disregards	Disregards	Disregards
EB	Disregards	Disregards	Disregards
EH	Counts	Disregards	Disregards
EI	Disregards	Counts	Disregards
EN	Counts	Counts	Counts
HG	Disregards	Disregards $2000	Disregards
LV	Disregards	Disregards	Disregards
MO	Disregards	Counts	Counts
OC	Counts	Counts	Counts
OI	Disregards	Disregards	Disregards
ON	Disregards	Disregards	Disregards

FMV: Enter the Fair Market Value of the resource entered. This is a required field if a resource type is entered.

Encumb: Enter the amount of any encumbrances against the resource entered.

Annl Rate Return: Enter the amount of the annual rate of return or income generated once a year from this resource. This amount has no affect on the resource value. However, consider if the generated income should be entered as earned or unearned income.

Document:
- ✓ Details of any resource listed on this screen
- ✓ Conversion or disposition of resources at review or interim change, including spousal impoverishment.
- ✓ For FBR cases, burial space exclusion if not evident from verification in record
- ✓ Any amount entered as “OC” due to burial exclusion policy

TRANSFER OF RESOURCES
TRAN

```
INTERVIEW                TRANSFER OF RESOURCES – TRAN                TRAN 01
 Month 11 06                                                           01

 Client Name HERBERT        BLACK                 Client ID 106594364

 Del   Transf  Discovery   Transferee   Resource    FMV      V      Amt       V
 Ind   Date      Date        R'Ship       Type                    Rec'd
      (MM YY)   (MM YY)




 Reason for   Undue Hardship     1st Mth
 Transfer      Ind   Rsn       NH/Wvr MA
                                (MM YY)

                                                                    More
 Message

            15-lett                                                24-del
```

INFORMATION

This screen is used to record information regarding a transfer of resources. It is a client level screen. However, only data entered on the TRAN screen for the A/R will result in a penalty. If a spouse transfers a resource that should result in a transfer penalty to the A/R, enter the data on the TRAN screen of the A/R. If transfer information is entered, all fields are mandatory on the screen except for Undue Hardship, which is optional.

KEY FIELDS

Del Ind: Using the delete indicator field will not result in deleting data entered on the TRAN screen. The only time using this field will work is if the case manager has not yet exited SUCCESS and committed information to the data base. However, data may be deleted by tabbing to each field and pressing the Delete or End key.

Transf Date: Enter the month and two digit year that the transfer actually occurred.

Discovery Date: Enter the month and two digit year in which the case manager learns of the transfer.

TRAN Screen (continued)

Transferee R'Ship: Enter the appropriate code for the relationship of the person to whom the resource was transferred. All of the codes, with the exception of NT Spouse Not Transferred, will result in a transfer penalty.

Resource Type: Enter the code for the type of resource, which was transferred. All of these codes will result in a penalty. If OT is used, the case manager must document.

FMV: Enter the Fair Market Value of the transferred resource and the appropriate verification code.

Amt Rec'd: Enter the amount of compensation received for the resource, if any. If no compensation was received, enter 0 or leave blank. If the field is left blank or 0 is entered, PF4 around the warning message. Enter an appropriate verification code.

Reason for Transfer: Enter the appropriate code to indicate why the individual transferred the resource. The code chosen may or may not result in a penalty.

D = To pay a debt does not result in penalty
E = To be eligible for assistance results in penalty
F = Intent to transfer FMV does not result in penalty
G = Gift results in penalty
I = Inaccessible trust results in penalty
L = Valid loan does not result in penalty
O = Other reason results in penalty
R = Resource returned does not result in penalty
S = Benefit of spouse does not result in penalty
T = Trust for disabled individual does not result in penalty
V = Intent to transfer valuables does not result in penalty

Undue Hardship: The Undue Hardship fields are only used if the penalty should be waived because it will cause a hardship situation to occur. Any hardship reason will negate imposition of a penalty.

1st Mth NH/Wvr MA: Enter the month and two digit year in which the A/R entered a NH or was placed in a home and community based waiver program.

NOTE: For instructions on how to reverse a transfer penalty, refer to the ABD Medicaid SUCCESS Functions portion of the online policy Medicaid Policy Manual.

Document:

- ✓ Details of any transfer and verification used or A/R's statement that no transfers have been made
- ✓ Details of any recalculation of penalty and verification used
- ✓ For Promissory Notes, Loans, Property Agreements that result in a transfer penalty explain how the penalty amount was calculated.

EARNED INCOME 1
ERN1

```
INTERVIEW                    EARNED INCOME 1 – ERN1                    ERN1 01
 Month 11 06                                                             01

 Client Name HERBERT        BLACK                 Client ID 106594364

 Do you have any of the following: wages, self employment, commissions/tips,
 roomer/boarder income, rent, mortgage payment, sick pay, work program, JTPA,
 Job Corps, training allowance, use/sale of personal property, or other income?

 Employer Name                                                    AJS Employ
 Line 1                              Line 2
 City                    ST      Zip              Phone
        Begin    First      End     Late   SON    $30+1/3    $30+1/3     $30
 Type   Date    Pay Date    Date    Rpt    Ovrd   Ind Cntr   End Date  End Date
                                          AFDC
                                           ARM

                             Num of  ABD Stdnt  AFDC Student ------JTPA----
                             Bordrs    Excl       Ind Cnt    Ind Cnt   Excl

                                                                 More Jobs
 Message 1943      1970
 1943 NO W-4 DATA AVAILABLE FOR DISPLAY
                 15-lett
```

INFORMATION

The ERN1 screen is used to enter the earned income of the household members. The system will count the income according to policy guidelines for the appropriate case type (ABD, FS, etc.) and class of assistance.

KEY FIELDS

AJS: This is a required field for FS AUs. It is not required for ABD only AUs. Enter a Y or N to indicate if the job was the result of an Applicant Job Search.

The **Employer Name**, **Type**, **Begin Date**, **First Pay Date** and **Late Rpt** are required fields. Late Rpt should never be coded Y for the ongoing month, since an A/R is always eligible for earned income disregards for next month, even if historically s/he is not. The address fields and phone number are optional.

The **SON Ovrd**, **$30+1/3 Ind Cntr**, **$30+1/3 End Date** and **$30 End Date** fields are only used for TANF and Family Medicaid AUs.

Num of Bordrs: When the earned income types of BO and RB are used for FS AUs, the case manager is required to enter the number of borders in the household. If the AU is ABD Medicaid only, this field is not required.

ERN1 Screen (continued)

ABD Stdnt Excl: This field shows a running total of how much of an ABD Medicaid individual's earned income has been excluded in the calendar year under the ABD Medicaid student earnings exclusion.

AFDC Student Ind and **Cnt**: These fields are for TANF AUs although Field Help shows it as ABD Student Ind and Cnt. These fields are no longer used as student earnings are always excluded. It was formerly used to apply to students in TANF cases whose earnings were excluded for 6 months during a calendar year. SUCCESS is programmed to budget income correctly based on age and financial responsibility.

JTPA Ind, Cnt and **Excl**: These fields are used for participants in the Job Training Partnership Act and applies to TANF A/Rs. JTPA is now WIA (Workforce investment Act).

An explanation of how earned income Type codes are counted in eligibility and patient liability/cost share budgets follows:

TYPE CODE	COUNTS FS	COUNTS NON-FBR	COUNTS FBR	COUNTS PL/CS
BO	Y, deducts self-employment expenses	Y	Y	Y
BS	Y	Y	Y	Y
EI	Y	Y	Y	Y
FM	Y	Y	Y	Y
GT	N	Y	Y	Y
IK	Y	Y	Y	N
JC	Y	Y	Y	Y
JT	Y	Y	Y	Y
LS	N	Y	Y	Y
MI	Y	Y	Y	Y
MP	Y	Y	Y	Y
OA	N	N	N	N
OF	Y	N	N	N
OJ	Y	Y	Y	Y
OM	N	Y	Y	Y
OT	Y	Y	Y	Y
PS	Y	N	N	N
RB	Y, deducts self-employment expenses	Y	Y	Y
RI	Y	Y	Y	Y
RO	Y	Y	Y	Y
SE	Y	Y	Y	Y
SH	Y	Y	Y	Y
SP	Y	Y	Y	Y

ERN1 Screen (continued)

TYPE CODE	COUNTS FS	COUNTS NON-FBR	COUNTS FBR	COUNTS PL/CS
SW	NA	NA	NA	NA
TR	N	N	N	Y
VI	Y	N	N	N
WS	Y	Y	Y	Y

Document:

- ✓ Current employment record to track employer's name, begin/end dates, reason for termination and how verified
- ✓ When clearinghouse (DOL) information automatically appears after matching on SSN for AU member's age 16 or older. When DOL information appears, press the tilde key and the information will copy and paste to the ERN1 REMA screen
- ✓ Discrepancies in clearinghouse information

EARNED INCOME 2
ERN2

```
INTERVIEW                    EARNED INCOME 2 – ERN2                    ERN2 01
 Month 11 06                                                             01

 Client Name HERBERT         BLACK                 Client ID 106594364

 Employer Name

                Avg Hrs ?     Freq ?    Day Week Pd      Extra Pay

 Del

   Amt 1    V    Amt 2    V    Amt 3    V     Amt 4   V      Extra    V
    ?
 --------------------------   Work Expenses  ----------------------------------
           Type  Amount   Freq  V        Type  Amount   Freq  V


                                                                   More Jobs
 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
           15-lett                        16-evnc          23-alau    24-del
```

INFORMATION

This screen is used to enter the amount of earned income for the AR indicated in the client pointer. It is a conditional screen and will only appear if ERN1 has been completed. If the AU member's earnings fluctuate, press PF16 to access the EVNC screen.

KEY FIELDS

Avg Hrs: Enter the average number of hours worked within the pay period.

Freq: Enter the code for the appropriate frequency of pay. The pay will be budgeted for the benefit month shown on a monthly basis according to the code entered as follows:

> AC: The individual's actual income will be budgeted. SUCCESS adds together all of the amounts entered.
>
> AN: The individual's annual income will be budgeted because the AR is paid once a year. SUCCESS budgets only the first amount entered and divides that amount by 12.
>
> BM: The individual's bi-monthly income will be budgeted because the AR is paid every other month. SUCCESS budgets only the first amount entered and divides by 2.

ERN2 Screen (continued)

BW: The individual's bi-weekly income will be budgeted because the AR is paid every other week. SUCCESS uses only the first amount entered and divides by 2 to get a weekly amount. That amount is then multiplied by 4 for ABD and by 4.3333 for FS.

MO: The individual's monthly income will be budgeted because the AR is paid once a month. SUCCESS adds together all of the amounts entered.

OT: This is the only payment the individual will receive. Remove for benefit months in which the individual does not receive. ABD only budgets the first amount entered. FS totals all the amounts entered for budgeting.

QU: The individual is paid once every three months. ABD does not budget any income entered with this frequency code. FS budgets the first amount entered and divides that amount by three.

SA: The individual is paid twice a year. ABD does not budget any income entered with this frequency code. FS budgets the first amount entered and divides by six.

SM: The individual is paid twice a month. SUCCESS budgets the first amount entered and doubles it.

WK: The individual is paid once a week. If only one amount is entered, for FS the system multiplies the amount entered by 4.3333, and for ABD it multiplies the amount entered by 4. If more than one amount field is completed, the system adds the amounts together to obtain a total amount for the benefit month.

Day Week Pd: Optional field for entering the day of the week the AU member is paid. PF1 for the codes for each week day.

Extra Pay: Enter a Y if the month has an extra pay period in it or the employee receives a bonus. Entering a Y if the frequency is weekly will cause the system to multiply by 5 for ABD; however, it does not affect the FS case. The FS case still will multiply the first amount by 4.3333.

ERN2 Screen (continued)

Work Expenses Fields: The work expenses entered are included with the other earned income deductions. For example for ABD, the total of work expenses is added to the $65 and one half to show the total of earned income deductions. For FS, the work expenses are included with the earned income deduction.

Type: Enter the appropriate code for the type of work expense. Only three are allowed per screen.

Amount: Enter the dollar amount of the work expense.

Freq: Enter the appropriate frequency code. It must be the same as the frequency of the pay entered on this screen above.

NOTE: Refer to ABD Medicaid SUCCESS Functions for instructions on how to enter earned income for an ABD Medicaid/FS Combination case.

Document:

- ✓ Hourly pay rate
- ✓ Tips, if not included in gross pay on the pay stubs
- ✓ Reason any pay period is NOT considered representative pay
- ✓ If actual income used in budgeting explain
- ✓ If verification is required but is not in case record, how was information verified For example: YTD, TC
- ✓ IF EVNC is not used, explain calculation and frequency of pay

EARNED VARIABLE INCOME CALCULATION EVNC

```
INTERVIEW          EARNED VARIABLE INCOME CALCULATION – EVNC         EVNC 01
 Month 11 06

 Client Name HERBERT        BLACK                  Client ID 106594364
 Del      Avg Hours        Freq       Day Week Pd        Extra Pay

        PP End Date   Pd/Rcvd Date    Amount          V         Repres
         MM DD YY





 Message

                                                                   24-del
```

INFORMATION

Use this screen when income fluctuates and an average of the earned income is needed. The averaged income will then appear on the ERN2 screen in the first Amt field with a verification code of VN. The average amount is then converted to a monthly amount on MAFI and FSFI. After entry is made on EVNC, the data on the ERN2 screen will always appear in blue. To make changes to the data, re-access the EVNC screen. EVNC is a conditional screen that is only accessed from ERN2 by pressing PF16. It is possible to enter up to 12 pay amounts on the EVNC screen. In order to access EVNC, the ERN2 fields must be blank.

KEY FIELDS

Avg Hours: This is a mandatory field. Enter the approximate average number of hours worked for the pay period frequency. This figure is not used in any calculations and is for documentation purposes only.

Freq: Enter the appropriate frequency code for the pay period entered:

AN: Individual is paid once a year. This amount is not reflected in the ABD budget. For FS, the budget reflects the average amount divided by 12.

BM: Individual is paid every other month. This income will not be counted in the ABD budget. For FS, the budgeted amount will be the average amount divided by two.

EVNC Screen (continued)

BW: Individual is paid every other week. For ABD, the budget will reflect the average amount multiplied by 2. For FS, the budget will divide the average amount by 2 then multiply by 4.3333.

MO: Individual is paid monthly. For ABD and FS, the budget will reflect the average amount.

OT: This code may only be used in the month of application.

QU: Individual is paid once every three months. This income is not counted in the ABD budget. For FS, the budget will reflect the average amount divided by three.

SA: Individual is paid twice a year. This income is not counted in the ABD budget. For FS, the budget will reflect the average amount divided by six.

SM: Individual is paid twice a month. For ABD and FS, the budget will reflect the average amount multiplied by two.

WK: Individual is paid once a week. For ABD, the budget will reflect the average amount multiplied by four. For FS, the budget will reflect the average amount multiplied by 4.3333.

Day Week Pd: Enter the code for the day of the week that the individual is normally paid. This is an optional field with no impact on the budget.

Extra Pay: Enter a Y if any of the pay entered is an extra paycheck. This has no impact on the budgeting.

PP End Date: Enter the month, day and two digit year of the pay period end date for this paycheck.

Pd/Rcvd Date: Enter the month, day and two digit year of the date the individual received this paycheck.

Amount: Enter the amount of the paycheck in dollars and cents, omit the dollar sign.

Repres: Enter a Y if this paycheck is typical of what the individual receives. Enter an N if the paycheck is not typical of what the individual receives. For example, if one paycheck reflects a lot of overtime, and the individual does not normally work overtime. If a code of N is entered, that paycheck is omitted from the averaging calculation. This is a mandatory field. Consult policy manual for definition of Representative Pay.

DEEM/ALLOCATE DEAL

```
INTERVIEW                    DEEM/ALLOCATE – DEAL                    DEAL 02
 Month 11 06

 Client Name SUSAN          BLACK                 Client ID 106565060

 -------------- Deemor Budget ---------------  ----- CS Paid Outside Home -----
 Num IRS Dep Alimony  V   Other Exp  V         Del  Oblig Amt  V   Paid Amt  V


 ------------- ABD Allocation ---------------
    Inelig                  Inelig
 Del Ind    Amount   V   Del Ind   Amount  V
                                                      Number Of
                                                      ABD Child
                                                      Appl Recip

 -------------- Alien Sponsor --------------- ---------- AF Allocation ------
 Amt Actually Contributed/V                    Client ID
 Number of Other Spons Aliens                  Who can
 Number of Other FS Recips Spons               Allocate to me

 Message

           15-lett                                          24-del
```

INFORMATION

For ABD Medicaid, the DEAL screen is used to allocate income to ineligible child(ren). Since income is allocated to ineligible children from the A/R's spouse's income, always access the spouse's DEAL screen to enter information for allocation. The allocation computation will not appear on MAFI until the AU is finalized.

KEY FIELDS

The only fields used for ABD Medicaid allocation are those that appear under ABD Allocation.

Inelig Ind: Enter a Y in the ineligible child indicator field for each ineligible child for whom allocation is to occur. These children do not need to be entered in the AU as household members.

Amount: Enter the amount of the child's own income and a verification code. If the child has no income, enter a 0 or leave the amount field blank. When the child has no income, it will be necessary to PF4 around the warning message.

DEAL Screen (continued)

Number of ABD Child Appl Recip: This field is only used when an adult A/R has child(ren) who are Medicaid eligible or who are applying for Medicaid (SSI or ABD). Enter the number of children in the household who fall into the category of a Medicaid applicant or recipient. Again this information is entered on the spouse's DEAL screen.

CS Paid Outside Home: Child support expense data is entered for FS AUs.

Oblig Amt: Enter the amount of child support this individual is obligated to pay each month to children not living with him/her.

Paid Amt: Enter the amount of child support the individual actually pays each month for children not living in the AR's home. If you are completing this screen for the ongoing month, enter your best estimate of what the individual will pay on an ongoing basis. The system will not deduct more that the obligated amount in the FS budget.

Document:

- ✓ Alien sponsor's name and address
- ✓ Ineligible children and type of income

UNEARNED INCOME
UINC

```
INTERVIEW                    UNEARNED INCOME – UINC                    UINC 01
 Month 11 06                                                             01

 Client Name HERBERT        BLACK                 Client ID 106594364

Do you have any of the following: RSDI, alimony, direct child support,
contributions, VA, workers compensation, unemployment, sick/disability benfits,
pension, railroad retirement, any other retirement, rent, interest, annuities,
dividends, educational income, or striker benefits?


 Type    Del   Freq   Claim Number  Ded    Ded Amt  V     Extra Pay


 Date Rcvd   Amount   V     Date Rcvd   Amount   V     Date Rcvd   Amount   V



                                Client Potentially Elig For Other Benefits?
                                                                      More
 Appl Type     Stat    Date                 Appl Type     Stat    Date
 Message 1968      1965      1970
 1968 NO SDX DATA AVAILABLE
          15-lett                        16-uvnc           23-alau  24-del
```

INFORMATION

The Unearned Income screen gathers information about the unearned income of the individual identified by the client pointer on the screen. Income from one source is entered per screen. If the individual has more than one type of unearned income, access another UINC screen by entering a Y in the “More” field in the bottom right hand corner of the screen. If an average amount is needed, press PF16 to access the Unearned Variable Income Calculation screen. The UVNC screen works the same as the EVNC screen.

KEY FIELDS

Type: Select the appropriate type of income from the list of valid values. The chart below explains how the income will be counted in the patient liability/cost share and the eligibility budgets for FS and FBR and Non-FBR ABD Medicaid COAs.

UINC Screen (continued)

UINC TYPE	$20 DEDUCTION	FS	FBR	NON-FBR	PL/CS
AA	N/A	Counts	Disregards	Disregards	Disregards
AF	N	Counts	Counts	Counts	Counts
AI	N/A	N/A	N/A	N/A	N/A
AL	Y	Counts	Counts	Counts	Counts
AN	N/A	Counts	Counts	Counts	Counts
AO	N/A	Disregards	Disregards	Disregards	Counts
AP	N	Counts	Counts	Counts	Counts
BL	Y	Counts	Counts	Counts	Counts
CC	N/A	Disregards	Disregards	Disregards	Disregards
CD	Y	Counts	Counts all but 1/3	Counts all but 1/3	Counts
CO	Y	Counts	Counts	Counts	Counts
CS	Y	Counts	Counts all but 1/3	Counts all but 1/3	Counts
CW	N/A	Counts	Disregards	Disregards	Disregards
DB	Y	Disregards	Counts	Counts	Counts
DI	Y	Counts	Counts	Counts	Counts
DR	N/A	Disregards	Disregards	Disregards	Disregards
EA	Y	Counts	Counts	Counts	Counts
EC	N/A	Disregards	Disregards	Disregards	Counts
EE	N/A	Disregards	Disregards	Disregards	Counts
EI	N/A	Disregards	Disregards	Disregards	Counts
EN	N/A	Disregards	Disregards	Disregards	Disregards
FA	Y	Counts	Counts	Counts	Counts
FC	N	Counts	Counts	Counts	Counts
FR	Y	Counts	Counts	Counts	Counts
FS	N/A	Disregards	Disregards	Disregards	Disregards
FT	Y	Disregards	Disregards	Counts	Counts
FV	N/A	Disregards	Disregards	Disregards	Counts
GA	N/A	Counts	Disregards	Disregards	Disregards
GO	N/A	Disregards	Disregards	Disregards	Disregards
GP	N/A	Counts	Disregards	Disregards	Disregards
HE	N/A	Disregards	Disregards	Disregards	Disregards
HI	N/A	Counts	Disregards	Disregards	Disregards
IK	Y	Disregards	Counts	Disregards	Disregards
IN	Y	Counts	Counts if > $20	Counts if > $20	Counts all
JC	Y	Counts	Counts	Counts	Counts
JT	Y	Disregards	Counts	Counts	Counts
LO	N/A	Disregards	Disregards	Disregards	Disregards
LS	Y	Disregards	Counts	Counts	Counts

UINC Screen (continued)

UINC TYPE	$20 DEDUCTION	FS	FBR	NON-FBR	PL/CS
LW	Y	Counts	Counts	Counts	Counts
MA	Y	Counts	Counts	Counts	Counts
OA	N/A	Disregards	Disregards	Disregards	Disregards
OC	Y	Counts	Counts	Counts	Counts
OF	N/A	Counts	Disregards	Disregards	Disregards
OL	N/A	Disregards	Disregards	Disregards	Counts
OM	Y	Disregards	Counts	Counts	Counts
ON	N/A	Disregards	Disregards	Disregards	Disregards
RB	Y	Counts	Counts	Counts	Counts
RC	Y	Disregards	Counts	Counts	Counts
RE	N/A	Disregards	Disregards	Disregards	Disregards
RF	N/A	Counts	Disregards	Disregards	Disregards
RI	Y	Counts	Counts	Counts	Counts
RR	Y	Counts	Counts	Counts	Counts
SA	Y	Counts	Counts	Counts	Counts
SB	Y	Counts	Counts	Counts	Counts
SC	Y	Counts	Counts	Counts	Counts
SE	N/A	Disregards	Disregards	Disregards	Disregards
SI	N	Counts	Counts	Counts	Counts
SR	Y	Counts	Counts	Counts	Counts
TF	Y	Counts	Counts	Counts	Counts
TI	N/A	Disregards	Disregards	Disregards	Counts
TR	N/A	N/A	N/A	N/A	N/A
UC	Y	Counts	Counts	Counts	Counts
VA	Y	Counts	Counts	Counts	Counts gives $30 PNA
VC	N	Counts	Counts	Counts	Counts gives up to $90 PNA
VE	Y	Disregards	Counts	Counts	Disregards
VI	N/A	Counts	Disregards	Disregards	Counts
VO	N/A	Disregards	Disregards	Disregards	Disregards
VP	Y	Disregards	Counts	Counts	Disregards
VT	N/A	Counts	Disregards	Disregards	Disregards
VU	Y	Disregards	Counts	Counts	Counts
WC	Y	Counts	Counts	Counts	Counts

UINC Screen (continued)

Freq: Enter the appropriate frequency code for the income type entered. The affect on the ABD and FS eligibility budgets are as follows:

AC: System budgets the actual amount as entered for ABD and FS.

AN: For ABD, the system budgets the actual amount entered. For FS, the system divides the total of the actual amount by 12.

BM: For ABD, the system budgets the actual amount entered. For FS, the system uses the first amount entered and divides by two.

BW: For ABD, the system uses the first amount entered and multiplies by two. For FS, the system uses the first amount entered, divides by two and then multiplies by 4.3333.

MO: System budgets the actual amount as entered for ABD and FS.

OT: For ABD, the system budgets the first amount entered. For FS, the system budgets a total of the amounts entered. Delete the income from the system for months in which it should not be budgeted.

QU: For ABD, the system budgets a total of the amounts as entered. For FS, the system uses the first amount entered and divides by three.

SA: For ABD, the system uses the actual amount as entered. For FS, the system uses the first amount entered and divides by six.

SM: For ABD and FS, the system doubles the first amount entered.

WK: For ABD, the system uses the first amount entered and multiplies by four. For FS, the system uses the first amount entered and multiplies by 4.3333.

Claim Number: The claim number is only a required field if the income type is either RR or SA. Enter the number and suffix with no spaces or dashes.

UINC Screen (continued)

Ded: If the individual has items deducted from their pay, enter the appropriate valid value. Below is an explanation of the impact on the eligibility and patient liability/cost share budgets as a result of using a particular deduction code.

DEDUCTION CODE	FS ELIGIBILITY	ABD ELIGIBILITY	PL/CS
BS – Books & Supplies	Deducts	No deduction	No deduction
FI – FICA	No deduction	No deduction	Deducts
FT – Federal Tax	No deduction	No deduction	Deducts
IP – IPV Recoupment	No deduction	No deduction	No deduction
ME – Misc Personal Expense	Deducts	No deduction	No deduction
MF – Mandatory Fees	Deducts	No deduction	No deduction
MT – Medicare Tax	No deduction	No deduction	Deducts
NI – Non IPV Recoupment	Deducts	No deduction	No deduction
OB – Expenses to Obtain Income	No deduction	Deducts	Deducts
OT – Other Expenses	Deducts	Deducts	Deducts
RC – Recoupment, same source	Deducts	No deduction	Deducts
RE – Rental Expenses	No deduction	Deducts	Deducts
SE – Self Employment Expenses	Deducts	No deduction	No deduction
SI (only with UINC code SA) – SSI Recoupment	No deduction	No deduction	No deduction
SS – Self Support Plan Expense	No deduction	Deducts	Deducts
ST – State Tax	No deduction	No deduction	Deducts
TR – Transportation	Deducts	No deduction	No deduction
TU (only with UINC code EA) – Educational Tuition and Fees	Deducts	Deducts	Deducts

Extra Pay: Enter a Y in this field when an individual gets an extra weekly or biweekly pay. There will be no impact on the FS budget; however, for ABD with a frequency code of weekly the 1st amount entered is multiplied by five and with a frequency code of biweekly, the weekly amount is determined and multiplied by five.

Date Rcvd: Enter the month, day and two digit year that the check is received. This cannot be a date in the future. The date entered will have no impact on the case. If the income is entered for a specific benefit month, it will be counted in the budget unless it is a type code that is disregarded. You may enter up to five payment dates and amounts on this screen.

UINC Screen (continued)

Client Potentially Elig For Other Benefits?: If the individual is potentially eligible for other benefits and has been required to apply for those benefits, enter a Y in this field.

Appl Type: Enter the appropriate valid value for the type of benefit for which the individual should apply. Up to two different benefit types may be entered per UINC screen. This is not a required field even if a Y indicates that the person is potentially eligible for other benefits.

Stat: Enter the appropriate status of the application for the other benefit. Remember to update or change when approve/deny.

Date: Enter the month, day and two digit year of the current status of the application for the benefit. Remember to change the date when the status changes.

Document:

- ✓ Date payments will begin and/or terminate
- ✓ The source and expected duration of any contributions
- ✓ Reason net instead of gross is used
- ✓ Calculation of monthly interest payment or child support payments, if needed
- ✓ Financial aid for students
- ✓ Reason for any changes to the auto update
- ✓ If A/R is receiving RSDI on someone else's account, the name and relationship,
- ✓ The reason any fluctuating income is not considered representative
- ✓ Details of application for any other benefits
- ✓ The results of clearinghouse (UCB/SDX/BENDEX) automatic matches and the resolution of any discrepancies
- ✓ Dates of award letters, bank statements, etc
- ✓ Reason for any deductions or exclusions, including for QITs
- ✓ Potential income based on past work history, spouse, etc
- ✓ If no income, document potential SSI eligibility
- ✓ Document receipt of or potential benefits for VA, when application filed with VA, etc.
- ✓ For Promissory Notes, Loans, and Property Agreements document any resulting countable income and how it was calculated.

PUBLIC LAW DISREGARD
PLAW

```
INTERVIEW                 PUBLIC LAW DISREGARD – PLAW                PLAW 01
 Month 11 06

 Client Name HERBERT        BLACK                 Client ID 106594364


              Client RSDI Claim Number           ?

              Previous SSI/MSS/AABD              ?

              Concurrent & Correct SSI/MSS/AABD  ?

              Date of SSI/MSS/AABD Inelig        ?

              Reason for SSI/MSS/AABD Inelig     ?

              RSDI Initial/Increase Entitlement  ?          V

              COLA Disregard Amt                 ?          V ?


Message 0013      0779
 0013 REQUIRED FIELDS ARE IDENTIFIED BY “?”
                15-lett
```

INFORMATION

The PLAW screen is where information is entered regarding the reason that an A/R lost SSI entitlement, the initial entitlement amount, COLA, date of loss of entitlement to SSI, and Social Security claim number. It is important that all of this information is entered correctly to ensure that the correct class of assistance is obtained. Frequently when a public law AU closes or trickles inappropriately, the error can be traced to this screen. This is a conditional screen that will only appear for Public Law COAs.

KEY FIELDS

Client RSDI Claim Number: Enter the A/R’s claim number without spaces or dashes. The Beneficiary Identification Code (BIC) which follows the Social Security number used should reflect what is acceptable for the COA. The claim number must be entered according to what SUCCESS will accept for the PL COA. Refer to the chart below for accuracy.

PLAW Screen (continued)

If the COA is:	Then the BIC should be:
SO2 – ’84 Disabled Widow(er)	W (no new A/Rs for this COA)
SO3 – Pickle	Any is acceptable
SO4 – Disabled Adult Child	C1, C2…
SO5 – Disabled Widow(er), 50-59	W
SO6 – Widow(er), 60-64	D

Previous SSI/MSS/AABD: Enter a Y if the A/R previously received SSI. Enter an N if the individual did not previously receive SSI. N will cause the AU to trickle to S95 or S99.

Concurrent & Correct SSI/MSS/AABD: Who was it that correctly and concurrently received SSI and RSDI? The codes are C = client; N = no one; and S = spouse. For S05 and S06 AUs the answer should be N since these individuals lost SSI due to initial entitlement. S for spouse may be acceptable in some couple situations where both were receiving SSI but only one member of the couple was receiving RSDI.

Date of SSI/MSS/AABD Inelig: The date entered in this field on the PLAW must not pre-date the date the Public Law was enacted. Check the policy manual for the specific PL COA to determine the enactment date.

Reason for SSI/MSS/AABD Inelig: Select the correct valid value for the reason why the A/R lost SSI eligibility based on the COA. The chart below will help select the correct valid value.

If the COA is:	Then the reason for ineligibility should be:
S02	(Should not be any new)
S03	C, E, I, O
S04	E, I, C
S05	E
S06	E

RSDI Initial /Increase Entitlement: Enter the amount of the initial entitlement to RSDI that caused SSI ineligibility or a non-COLA increase in RSDI entitlement that caused the individual to lose SSI.

COLA Disregard: Enter the amount of the total disregard based on the COA. This can be either the COLA or the initial entitlement or both. This should be changed annually at review. At initial application, S05 and S06 A/Rs will not have a COLA amount to enter.

Document:

- ✓ How determination was made and why person is eligible
- ✓ Yearly COLA

WORK REGISTRATION/PARTICIPATION WORK

```
CHANGE                        WORK REGISTRATION/PARTICIPATION – WORK                WORK 01
Month 11 06

Client Name HERBERT        BLACK                              Client ID 777006064


      ------------  Employment Services  ---------------          - Applicant Job Search –
     Exempt             Partic     Number  Comp   Supp  DA/PE    Non-Partic  AJS Start
     Reason Stat V       Date      Offns   Req    Work           Reason        Date
 CA
 FS    AG    NI  CS   10 16 06


                                                   15  -  FS ABAWD Non-Compliance  - -
 High School                              Non-compliance   Regain Dates    2nd 3 Months
  Grad/GED                              Bnft mth/yr         Start     End      Bnft mth/yr
     Y                                     1    ?
                                           2
                                           3


 Message 1985
 1985 SHOULD NON-COMPLIANCE BENEFIT MONTH DATA BE ENTERED AT THIS TIME?
             16-esme                    17-mo< 18-mo>                              23-alau
```

INFORMATION

This screen is used to enter information regarding Employment Services status for TANF and FS recipients. It will automatically appear if there is either a TANF or FS AU. The use of this screen will be discussed as it pertains to FS.

KEY FIELDS

Exempt Reason: This field may be automatically pre-populated under some circumstances. However, it may be changed if needed. If the individual is **not** aged, blind or disabled and has no income, then the case manager will need to enter an exempt reason code if this individual is exempt from meeting work requirements.

WORK Screen (continued)

IF	THEN
Disability information is entered on the DEM2 screen and tied to a Federal approval source,	The exempt reason code will automatically appear as FE (disability approved by federal).
The individual's age is 65 or older or under age 18,	The exempt reason code will automatically appear as AG for aged.

STAT: Enter the appropriate status for employment services according to policy. If the system determines that the individual is exempt for any reason, the status code is NI, exempt from participating.

V: Enter the appropriate valid value to indicate verification reason for exemption.

Partic Date: The system will update this date.

Number Offenses: The system will update this field based on the number of occurrences of non-cooperation with employment services.

Supp Work: The system will update this field with Y if the individual has an earned income type of SW for Supported Work.

DA/PE: This field is no longer required to be coded.

Applicant Job Search: Complete this field for FS if an ABAWD must receive employment services to regain eligibility after a sanction and FS eligibility depends upon cooperation with an E&T requirement. This field opens the E&T case prior to FS certification.

High School Grad/GED: This is a required field to enter a Y or N to indicate if the individual has a high school diploma or a GED.

FS ABAWD Non-Compliance: This field records the specific months in which the ABAWD received FS but was in non-compliance with work requirements. SUCCESS will remove the individual, or close a one person AU, if three non-compliance months are entered with no start and end regain dates.

SHELTER EXPENSES
SHEL

```
INTERVIEW                    SHELTER EXPENSES – SHEL                        SHEL 01
Month 11 06                                                                Remarks
Client Name HERBERT   BLACK                                      Client ID 777006064

Primary   Receive  Public         SUA                    Number          Phone
Heat/Cool LIHEAP   Housing/Exc    Type        V         Sharing          STD
    G                              HC        CS

Expense Type              Amt     V           Expense Type                Amt     V
   Rent                   250      ?                Mortgage
   Taxes                                            Insurance
   Electric                                         Gas
   Telephone                                        Sewer
   Water                                            Disaster Repair
   Garbage                                          Oil
   Other Housing                                    Other Fuel


Landlord Name MARY           HILL                                Phone   770 987 9876
Address  122 BROAD ST      City NEWNAN                 ST  GA      Zip  30305

Message

          15-lett
```

INFORMATION

The SHEL screen is a conditional screen which appears for FS AUs. It is used to enter expenses related to maintaining a household. These expenses may impact the amount of the FS allotment. It is a client level screen, so more than one person in the AU may have data entered on his/her SHEL screen.

KEY FIELDS

Primary Heat/Cool: Enter the valid value which best reflects how the home is heated and cooled.

Receive LIHEAP: Enter a Y or N to indicate if the household receives assistance from the Low Income Energy Assistance Program.

SHEL Screen (continued)

Public Housing/Exc: Enter a Y or N to indicate if the household lives in public housing and pays excess utility expenses.

SUA Type: Enter the valid value which best reflects the Standard Utility Allowance which the household is eligible to receive.

Number Sharing: For benefit months beginning 10/02, SUCCESS has been programmed to disregard this field. For months prior to 10/02: Enter the number of FS AUs which are sharing payment of housing and utility expenses. This field tells the system how to divide both shelter and utility expenses. If the household splits rent and utility expenses with another household, enter 2. You would then enter the total amounts of the shelter and utility costs paid by both households in the appropriate fields. One FS household will then get a deduction of half of what is reflected on the screen. If more than one AU shares the rent/mortgage but not utilities, or vice versa, code this field 1 and list the amount each AU pays on each HOH's SHEL screen.

Phone STD: If the household has a phone, enter a code of OW to indicate ownership, as households no longer rent phone equipment. The phone standard is only budgeted if AC is coded in SUA Type or is blank.

Expense Type: Enter the amount of the various household expenses and verification code in the spaces provided. Enter the average utility amount only if AC is coded in SUA Type. Utility amounts should not be entered if the heating/cooling or non-heating/cooling SUAs are coded as SUA types.

Landlord Name, **Address**: There are three fields provided to enter the first name, middle initial and last name of the landlord. These are optional fields. Enter the phone number, street name, city, state and zip code for the landlord.

INKIND SUPPORT & MAINTENANCE ISM1

```
INTERVIEW              INKIND SUPPORT & MAINTENANCE 1 – ISM1          ISM1    A
 Month

 HOH Name                                              AU ID 106514343
 HH Expense Type     Amt     V           HH Expense Type      Amt    V
   Rent                                    Mortgage
   Electric                                Taxes
   Gas                                     Water
   Sewer                                   Garbage
   Heating Fuel                            Insurance
   Food                                    Other

   Clients Contrib           Outside Contrib          Inside Contrib
 Type        Amt     V    Type        Amt     V    Type        Amt     V
 Food                     Food                     Food
 Shelter                  Shelter                  Shelter
 Other                                             Other

 Number    Sharing   Household     Ownership    Parent/
 Food      Shelter   Situation     Rent Lib     Child

 Message

                 15-lett
```

Do not complete

Do not complete

Do not complete

Do not complete

INFORMATION

The ISM1 screen is a conditional screen and only appears for S Track and Katie Beckett Waiver AUs. It is used to determine what, if any, ISM should be counted in the AU. ABD Medically Needy AUs are always treated as LA-A. The ISM1 screen does not work correctly, and therefore some workarounds are necessary in some situations to make it compute ISM accurately. The first four fields at the bottom of the screen are always required. Others may be required depending on what is entered under Household Situation. Never complete the household operating expenses fields or the client's contribution or inside contribution fields.

SEE INSTRUCTIONS ON THE FOLLOWING PAGE

Document:

- ✓ Details of determination of ISM, including manual budget or "see Form 969 in case record"

ENTERING ISM IN SUCCESS

Complete a manual budget, Form 969, to determine countable ISM.

Do not complete the “Household Operating Expenses”, the “Client’s Contribution” or the “Inside Contribution” fields. These fields do not work to accurately compute the value of ISM.

Enter the total number of people in the household who is applying for Medicaid in the fields “Number Food” and “Sharing Shelter”.

IF	THEN CODE HOUSEHOLD SITUATION
AR HAS NO COUNTABLE ISM	AL
A/R HAS ISM THAT EXCEEDS THE PMV, SO PMV SHOULD BE COUNTED	OF
A/R LIVES WITH OTHERS AND THEY FURNISH FOOD & SHELTER, LA-B	OF
AR HAS AN AMOUNT OF ISM BETWEEN ZERO AND THE PMV	AL ……AND CODE “Number Food” and “Sharing Shelter” as 01 …..AND ENTER THE ISM AMOUNT in the “Outside contribution” fields, dividing the amount between food and shelter. Do this regardless of whether the ISM is “Outside” or “Inside”.
A/R & SPOUSE ARE APPLYING AS A COUPLE OR CHILD APPLYING FOR KATIE BECKETT	SP

See Appendix I-8

Situation One:

Mary and Todd Williams own their home.
Mrs. Williams is applying for ABD Medically Needy.
5 Household Members (includes Mr. and Mrs. Williams, their son, and Mrs. Williams' Aunt and Uncle)

Mary Williams is the A/R.

Expenses are:

Mortgage	$400
Electricity	$110
Food	$500
Total	$1010

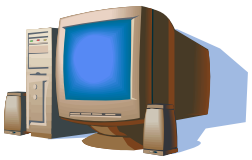
Pro rata share:
$1010 ÷ 5 = $202

Consider $5 tolerance
$197 minimum meets sharing

She pays $200, therefore she is not charged Inside ISM.

There is no Outside ISM.

HOW WOULD YOU CODE SUCCESS?



INQUIRY INKIND SUPPORT & MAINTENANCE 1 - ISM1 A
Month

HOH Name **Mary Williams** AU ID

HH Expense Type	Amt	V	HH Expense Type	Amt	V
Rent			Mortgage		
Electric			Taxes		
Gas			Water		
Sewer			Garbage		
Heating Fuel			Insurance		
Food			Other		

Clients Contrib			Outside Contrib			Inside Contrib		
Type	Amt	V	Type	Amt	V	Type	Amt	V
Food			Food			Food		
Shelter			Shelter			Shelter		
Other						Other		

Number	Sharing	Household	Ownership	Parent/
Food	Shelter	Situation	Rent Lib	Child
01	**01**	**AL**	**Y**	

Message

15-lett

Documentation on REMA

See Form 969 in case record. LBD 10/5/06 1222

Situation Two:

Mrs. Larson is the A/R.

One Household Member

Applying for ABD Medically Needy

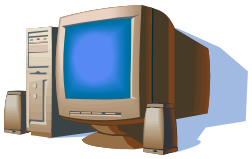
Rents her home

No Inside ISM

Outside ISM $400 – Her son pays the rent directly to the Landlord. A/R pays all other expenses.

Charge Presumed Maximum Value (PMV)

HOW WOULD YOU CODE SUCCESS?



INQUIRY INKIND SUPPORT & MAINTENANCE 1 - ISM1 A
Month

HOH Name **Laura Larson** AU ID

HH Expense Type	Amt	V	HH Expense Type	Amt	V
Rent			Mortgage		
Electric			Taxes		
Gas			Water		
Sewer			Garbage		
Heating Fuel			Insurance		
Food			Other		

Clients Contrib			Outside Contrib			Inside Contrib		
Type	Amt	V	Type	Amt	V	Type	Amt	V
Food			Food			Food		
Shelter			Shelter			Shelter		
Other						Other		

Number Food	Sharing Shelter	Household Situation	Ownership Rent Lib	Parent/ Child
01	**01**	**OF**	**Y**	

Message

15-lett

Documentation on REMA

See Form 969 in case record. LBD 10/5/06 1222

Situation Three:

Mrs. Larson is the A/R.

One Household Member

Applying for ABD Medically Needy

Owns her home

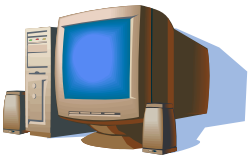
No Inside ISM

Mrs. Larson's son gives her $400/month to pay her mortgage

No Outside ISM

Contribution of $400 counted as unearned income

HOW WOULD YOU CODE SUCCESS?



INQUIRY INKIND SUPPORT & MAINTENANCE 1 - ISM1 A
Month

HOH Name **Laura Larson** AU ID

HH Expense Type	Amt	V	HH Expense Type	Amt	V
Rent			Mortgage		
Electric			Taxes		
Gas			Water		
Sewer			Garbage		
Heating Fuel			Insurance		
Food			Other		

Clients Contrib			Outside Contrib			Inside Contrib		
Type	Amt	V	Type	Amt	V	Type	Amt	V
Food			Food			Food		
Shelter			Shelter			Shelter		
Other						Other		

Number	Sharing	Household	Ownership	Parent/
Food	Shelter	Situation	Rent Lib	Child
01	**01**	**AL**	**Y**	

Message

15-lett

<u>No information is entered above the last line on the ISM1 screen in this situation. The $400.00 that Mrs. Larson receives is unearned income and is entered on the UINC screen.</u>

Documentation on REMA

See the UINC screen. LBD 10/5/06 1222.

Situation Four:

Mrs. Jones is the A/R.

Applying for ABD Medically Needy

Lives with her daughter, and her daughter's husband and child.

Mrs. Jones contributes $400 to help with household expenses

Expenses are:

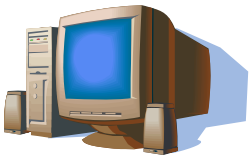
Mortgage	$1500
Electricity	$ 110
Food	$ 500
Total	$2110

Pro rata share:

$2110 ÷ 4 = $527.50
No Outside ISM

$527.50 - $400 = $127.50 countable ISM

HOW WOULD YOU CODE SUCCESS?



INQUIRY INKIND SUPPORT & MAINTENANCE 1 - ISM1 A
Month

HOH Name **Joan Jones** AU ID

HH Expense Type	Amt	V	HH Expense Type	Amt	V
Rent			Mortgage		
Electric			Taxes		
Gas			Water		
Sewer			Garbage		
Heating Fuel			Insurance		
Food			Other		

Clients Contrib			Outside Contrib			Inside Contrib		
Type	Amt	V	Type	Amt	V	Type	Amt	V
Food			Food	**63.75**	**cs**	Food		
Shelter			Shelter	**63.75**	**cs**	Shelter		
Other						Other		

Number Food	Sharing Shelter	Household Situation	Ownership Rent Lib	Parent/ Child
01	**01**	**AL**	**N**	

Message

15-lett

Documentation on REMA

See Form 969 in case record. LBD 10/5/06 1222

AU NON-FINANCIAL MISCELLANEOUS MISC

```
INTERVIEW           AU NON-FINANCIAL MISCELLANEOUS - MISC            MISC    A
 Month 11 06                      0097   10 30 06

 HOH Name HERBERT        BLACK                 Client ID 106594364
 AU ID 106514343    Prog MA

Pre    Pre   AU  ATP  ATP  QRF   QRF Pre- Calc Trial Pro Exp SLAM -Extended MA-
Issn   EBT  Issn Prnt Cyc Status Ctr sump Elig  HH   Ovr Svc  Cd  Start Dt  COA
       Card Mode Cnty Num  Code      Elig Ind   Ind                          Cor


 ----- Review ----   Auto   ------- Lump Sum Remainder ------  Delay  QMB   RSM
Compl  Mand  Last  Reasgn  Amount    100 %    133 %    185 %   Rsn   Ovr   Elig
       Std   Type   Ovr                                                    Ovr
                     N
 Sched Interview          QC Penalty End Date
 Del      Unit Number 106502     Inquiry Date 10 16 06       Load ID
      Next Review                   Appt Date                Appt Type
      Appt Begin Time (HH:MM)    :
      Appt End Time (HH:MM)      :           Appt Letter Print Location L
      L Name/Appt Remarks
 Message

 13-note 14-schd 15-lett                         20-schs       23-alau
```

INFORMATION

The MISC screen is an AU level screen and will appear for each AU. Non-financial information for each AU is shown on this screen. This screen also provides review information, allows appointments to be scheduled, and displays issuance information.

KEY FIELDS

Calc Elig Ind: Enter a Y if you would like the system to rerun eligibility. Usually the system will do this automatically; however, by entering a Y, this forces the system to look at eligibility again based on current data.

Trial HH Ind: Enter the number of additional members to the household to have the system complete a trial budget to show the impact of these additional members. Use only if running trial eligibility.

Pro Ovr: Enter a Y in this field if you do not want the system to prorate FS benefits for the benefit month indicated in the benefit month field.

Exp Svc: If you wish to override the FS expedited code determined by the system, enter the appropriate code in this field. Enter E for expedited or U for un-expedited.

MISC Screen (continued)

Review: The next three fields are to be used upon completion of a review.

Compl: Enter a Y in this field when the review is complete.

Mand Std: Enter an S or A to indicate if the next review should be standard or alternate. If the review type does not match between related AUs, a warning message will appear. If you do not want them to match, press PF4 to bypass the warning message.

Last Type: This field indicates the review type of the current review.

Auto Reasgn Ovr: This field is pre-populated with an N. If you want to retain this AU in your caseload, change the N to a Y.

Delay Rsn: If this AU is OSOP, enter the appropriate valid value to reflect the reason for the delay. Be sure to document if further explanation is needed.

QMB Ovr: Enter the two digit month and year that you would like for QMB (Q01) eligibility to begin. It is best to enter this in the interview function. It is only appropriate to use this field to affect the eligibility begin date when the AU is OSOP due to agency delay.

Sched Interview: The next few fields relate to scheduling or changing an interview.

Del: To delete this interview appointment from the schedule and to delete all information pertaining to the interview, enter a Y and press PF 24. If the scheduled appointment is a review, be sure to delete it before the 15th of the month to ensure that the appointment letter is not mailed.

Inquiry Date: The inquiry date is automatically entered to show the current date. If you wish to inquire on the schedule for a different date, key over the current date with the date for which you wish to inquire and press PF14.

Load ID: Enter the caseload ID for the case manager completing the interview.

Next Review: Enter S or A based on the type of review. If the system has automatically scheduled the review, it may be changed from this screen. If an alternate review has been scheduled and is subsequently changed to an alternate, the review data will be automatically deleted from the schedule.

MISC Screen (continued)

Appt Date: Enter the date (MM/DD/YY) for the interview. If this is a system scheduled standard review, the date will automatically appear in this field. To change this date, simply key over the existing date. This will cause the old date to be removed from the schedule and reappear on the new scheduled day.

Appt Type: Enter the valid value for the type of appointment you wish to schedule. If this is a system determined interview, the code will automatically appear in this field.

Appt Begin/End Time: Enter the time you wish the appointment to begin and end. The appointment times must fall on the hour or half hour. If the system has automatically scheduled the appointment, the begin and end times will appear in these fields. To change the appointment times, key over the existing time to the new time.

Appt Letter Print Location: The appointment print location is automatically shown as L to print locally. However, it will also be printed in batch, even if the print location is L. It may be changed to B to print in batch or N to not print a letter.

L Name/Appt Remarks: Enter the remark you wish to appear on your schedule to alert you to this interview. At a minimum, enter the A/R's name.

NOTE: To add text to the notice which will be generated, press PF13. If this is for a review, be sure to add text prior to the 15th of the month. Also letter templates, individual schedule, unit schedule and alerts may be accessed from this screen by pressing PF14, 15, 20 and 23 respectively.

Document:

- ✓ Why the case is over the SOP (Valid Value is never sufficient)
- ✓ QMB override reason

SPENDDOWN MEDICAL EXPENSES SDME

```
UPDATE            SPENDDOWN MEDICAL EXPENSES - SDME          SDME 01
Month 11 06                                                   01

 HOH Name    HAZEL          HARRISON              Client ID XXXX66262
 AU ID XXXX23422

 Del  Expense    Amt   V        Date          TPL     A/R   Exp Pd   SD
      Covered                 Incurred        Amt     Bill  Rollover Use

    Provider Name                              Expense Type

    Provider Name                              Expense Type

    Provider Name                              Expense Type

    Provider Name                              Expense Type

    Provider Name                              Expense Type

                                  Client Liability Amt for Breakeven Bill
                                                            More Med Exp
    Message
       15-lett                                                 24-deL
```

INFORMATION

The SDME screen is used to record the medical expenses of the A/R and family members whose bills may be used to meet the A/R's spenddown. Bills do not necessarily need to be entered in chronological order since the system will do that internally. However, the system does not rearrange them in chronological order, but displays them as entered. Remember that once the SD has been authorized, you will not be able to re-access SDME Update to make changes or corrections. Don't authorize SD until you are sure all bills have been received from the A/R. Review Entering SD Medical Expense on SDME in the ABD Medicaid SUCCESS Functions section of this Participant Guide.

KEY FIELDS

Expense Covered: Enter a Y or N to indicate whether the bill potentially may be Medicaid covered. Most medical bills incurred in the same month as the benefit month will be coded as Y. Always enter an N if the medical bill is:

- incurred in a month other than the SD benefit month
- not a Medicaid covered drug (such as over the counter medicines)
- incurred by a non-A/R

SDME Screen (continued)

Amt: Enter the dollar and cents amount of the medical expense. Use an appropriate verification code.

Date Incurred: Enter the two digit month, day and year in which the bill was incurred.

TPL Amt: Enter the dollar and cents amount that has been or will be covered by any insurance or other TPL.

A/R Bill: Enter a Y or N to indicate if the bill was incurred by the A/R.

Exp Pd Rollover: Enter the appropriate valid value for the medical expense:

P = bill has already been paid
R = bill is not Medicaid covered and will be a rollover bill used in subsequent months
U = bill has not yet been paid

SD Use: The system will enter data in this field to indicate whether the bill has been used to meet spenddown. The bill that is used to meet the SD will be flagged with a B to indicate the breakeven bill. The system will display the SD Use code after SD has been authorized.

Provider Name: Enter the name of the entity that provided the service. Example: Dr. Smith. This is a free form field.

Expense Type: Enter N if the expense is not for a prescription. Enter Y if the expense is for a prescription.

Note: If the breakeven bill is for an A/R and is potentially covered by Medicaid (the fields marked A/R Bill and Expense Covered both contain Y), complete Form DMA-400 for the breakeven bill and any other bills incurred on that day that were not used to meet SD. The breakeven bill will have the First Day Liability amount entered on the form. The subsequent bills will have a zero entered as the FDL. The DMA-400 may be completed on the system using the Letters function and Form number of M400.