Georgia Department of Human Services

Health Coverage Addendum

Please answer the following questions if you are applying for Health Coverage
(Please complete all three pages of this form)

1. If you are an adult applying for Health Coverage for your dependent child(ren), do you want to receive Health Coverage for yourself? ❑ Yes ❑ No
2. Is anyone in the household pregnant? ❑ Yes ❑ No If **yes**, how many babies are expected during this pregnancy? _____
3. Is anyone applying for health coverage blind or disabled? ❑ Yes ❑ No
   If yes, please list_____
4. Does anyone have other health insurance that covers anyone in your household? ❑ Yes ❑ No
5. If you answered yes to question 5 above, please complete the following information:

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

6. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.
   ❑ Yes If **yes**, you'll need to complete Attachment A. Is this a state employee benefit plan? ❑ Yes ❑ No
7. Have you or anyone listed on this application lost any health coverage in the last 2 months?
   ❑ Yes If **yes**, why was it lost? _____
   ❑ No
8. Was anyone in your household in Foster Care at age 18? ❑ Yes ❑ No
9. Does anyone in the household have any unpaid medical bills from the last 3 months? ❑ Yes ❑ No
10. Is anyone in your household American or Alaska Native? ❑ Yes ❑ No
    If Yes, complete Attachment B.

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If you are applying for Aged, Blind or Disabled Medicaid please answer questions 11-16 and complete the Resources section. Otherwise, skip to the tax filer questions on page 3.

11. Are you or your spouse currently covered by Medicare?
    ❑ Yes ❑ No If Yes please list, _____
12. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?
    ❑ Yes ❑ No If yes, date of SSI application: _____
13. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?
    ❑ Yes ❑ No
14. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
    ❑ Yes ❑ No

15. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?
❑ Yes ❑ No

16. Are you applying for Medicaid to help pay for community based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?
❑ Yes ❑ No

Resources: Check all resources (assets) owned by you, your spouse, your dependents or jointly owned with someone else. Attach additional pages if necessary.

Checking Accounts ❑ Yes ❑ No
Savings Accounts ❑ Yes ❑ No
Government Bonds ❑ Yes ❑ No
Trust Funds ❑ Yes ❑ No
Funeral Plans/Prepaid Burial Item ❑ Yes ❑ No
Burial Plots or Contracts ❑ Yes ❑ No
Stocks and Bonds ❑ Yes ❑ No
Other (IRA, CD, etc.) ❑ Yes ❑ No
Real Property/Homeplace Property ❑ 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, please describe below.

Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.

Does anyone in the household own a vehicle? If so, please describe below. ❑ Yes ❑ No

Vehicle Make	Model	Year	Amount Owed

Do you or your spouse have a life insurance policy? ❑ Yes ❑ No
If yes, please complete the following information.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ❑ Yes ❑ No
If **yes**, who? (list each person who plans to file)_____

2. Will any of the tax filers listed file jointly with a spouse? ❑ Yes ❑ No If **yes**, please list spouse's name:_____

3. Will any of the tax filers claim any dependents on their tax return? ❑ Yes ❑ No If **yes**, please list name(s) of dependents:_____

4. Will anyone be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If **yes**, please list the name of the tax filer and the dependent:_(Filer)_____
(Dependent)_____
How is the tax dependent related to the tax filer? _____

Income and Earnings: List all types of earnings and income that your household receives. List the income amount before deductions such as taxes, insurance or Medicare premiums , health insurance, dental, and vision premiums or Spending accounts are taken out.

Income Type	Gross amount	How often? (weekly, every 2 weeks, monthly, etc.)	Name of Person Receiving
Wages/Salary			
Current Employer:			
Wages/Salary			
Current Employer:			
Self Employment			
Unemployment Benefits			
Social Security Income			
SSI			
Worker's Compensation			
Pension/Retirement Benefits			
Veterans Benefits			
Child Support			
Alimony			
Contributions			
Other Income (please specify)			

Does anyone expect any change in monthly income? ❑ Yes ❑ No
If yes, please list who expects the change, the type of income that is changing, and the date it is expected to change below.

_____

Deductions: Check all that apply, and give the amount and how often you pay it.

❑ Alimony $_____ How often? _____ ❑ Other Deductions $_____ How often?_____

❑ Student loan interest $_____ How often?_____

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/her eligibility for Medicaid.) 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. I agree to give the State the right to require an absent parent to provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do **not** cooperate, I understand I may lose my Medicaid benefits, and only my child(ren) will receive benefits unless good cause is established.

I certify, under penalty of perjury, that all the information listed is truthful to the best of my knowledge.

_____ _____
Signature Date

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the United States Department of Homeland Security (DHS) of my and/or my child(ren)'s citizenship or immigration status when seeking benefits. Information received from DHS may affect my or my child(ren)'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)	(Check applicable) U.S. Citizen	(Check applicable) Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID # (If applicable)
					A-
					A-
					A-
					A-
					A-

I, _____, declare the child/children is/are a U.S. Citizens or a Qualified Immigrant.
(PRINT NAME)
I attest to the identity of the child/children listed above, and 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)	(Check applicable) U.S. Citizen	(Check applicable) Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID # (If applicable)
					A-
					A-

I, _____ , declare I am a U.S. Citizen or a Qualified Immigrant. I certify under
(PRINT NAME)
penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (DATE)